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CLINICAL LECTURE.[1]

CASE I: CEREBRAL SYPHILIS; CASE II: ASTHMA CAUSED BY A FOREIGN BODY.

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Cerebral Syphilis.

Gentlemen: The patient now before you (a man, about 40 years of age) you saw at our last meeting, when I read you his clinical history. Briefly, it was this: He had had frequently recurring attacks of convulsions, limited to the left arm, occasionally the right arm also would participate in the spasmodic movements, though not to the same degree. He never had general convulsions, and the lower extremities were never involved. These attacks were attended by vertigo and confusion of ideas. He had constant tinnitus aurium, and in addition to the ordinary sounds of escaping steam and chiming bells, he heard sounds resembling a band of music and even human voices; all these being increased during and after the attacks, which came on several times a day before his admission. We ascertained that he had no paralysis of the extremities, and sensation is well preserved. He does not suffer with headache. He does not lose consciousness during the attack, and does not vomit. There is marked diminution of the power of hearing in both ears, but he is more deaf on the left side than on the right. His eyes were examined, and, beyond some error of refraction, nothing abnormal was found. There is no heart-lesion; and no albumin was detected in the urine.

In seeking an explanation of these symptoms, which I have briefly detailed to you, two possibilities are presented: in the first place, is this a tumor of the brain? In favor of this view, we have the convulsions limited to the muscles of the left arm. Limited convulsive movements point to an irritative cortical lesion, such as a tumor would

[1] Delivered at the Pennsylvania Hospital, December 1, 1888.

cause. The vertigo aggravated during the attacks, but occurred also at other times, is one of the symptoms of brain tumor. Then the deafness, unconnected with ear disease, and therefore central, might be caused by pressure of a new growth upon the auditory nerve. Why do we have the ear-affection upon the same side as that of the arm affected by convulsions? Because the law is that while a destructive lesion will cause paralysis upon the opposite side of the body, an irritative cortical lesion causes spasm upon the same side as that upon which it exists. But why does the right arm participate at times? I can only conclude that its movements are reflex. Brown-Séquard would have no difficulty in thus explaining it, because he believes that most of the phenomena of brain disease are due to the reflex action of one part of the brain upon another.

In spite of the reasons given for assuming that the symptoms are due to a cerebral tumor, I must decide against this view for several reasons. In the first place, the symptoms just mentioned are not sufficiently persistent. The symptoms of brain tumor are progressive, and constant. Moreover, one very prominent feature of cases of brain-tumor is entirely absent; he has no headache. He has no vomiting. Finally, the ophthalmoscopic examination does not show the choked disc which is so generally found in cerebral tumor. The report is that the eye-ground is quite normal, his ametropia being simply an ordinary fault of refraction which can be remedied by appropriate glasses.

The case not being one of tumor, my diagnosis would be disease of the brain or of its vessels, due to syphilitic infection: cerebral syphilis. His marked improvement since his admission a fortnight ago, while he has been taking a drachm of potassium iodide daily, would favor this view of the case. He has also had some bromide at night. He is doing well and has no vertigo at present, although he still has ringing in his ears. Standing or walking with his eyes closed, he gives no evidence of incoördination. He has not had a convulsive seizure since he was before you last; the treatment will be continued for the present.

[Feb. 1. The patient is still in the Hospital, but has very greatly improved.]

Asthma Caused by a Foreign Body.

The next case is peculiar and possibly unique in character. It is also one of convulsions, and therefore very properly discussed in connection with the preceding case, although it presents special features which are of more interest than the brain symptoms.

This boy, white, sixteen years of age, was admitted November 26, having been brought to the Hospital by the Police Patrol, who found him lying on the street in a fit, which was clearly epileptic in character. We learned that this boy received an injury by being struck with a brick on the left side of his head, about six years ago. He tells us that about two years after he was struck upon his head, convulsions came on. In spite of treatment, the convulsions persisted, and they became so frequent that he had to seek surgical advice. Two years ago, at the Hospital of the University of Pennsylvania, Dr. John Ashhurst trephined his skull at a point which can be still recognized; it is above and on a line with the left ear, at about the centre of the parietal bone, where a depression can still be felt. He says that, at first, no relief was obtained from the operation, but that lately there has been improvement; the convulsions now occur about once in three weeks; he had them sometimes twice a day before the operation. It is a fair inference that he was benefited by the operation, although he says that for about eighteen months there was no benefit, yet since that time he has markedly improved.

The special point to which I wish to ask your attention is this: On the 26th of November, the day he was brought into the Hospital, he had a fit or attack of convulsions upon the street, and became senseless. As he was recovering from the attack, he experienced great difficulty in breathing. When he came to the Hospital he was conscious, but was suffering intensely with difficulty in breathing. His respiration was labored and noisy, like that of asthma, and the expression of his face showed that he was laboring under great respiratory distress. He was seen by one of my colleagues, who happened to be present when he was admitted, and who kindly went into the ward and prescribed for the patient. Partly from his account and partly from that of the Resident Physician—for I did not see the patient until half an hour later, when he was somewhat relieved—we learn that the breathing was noisy, the inspiration weak, and the expiratory sound was prolonged. It was especially upon the left side that the expiratory sound was asthmatic; in fact, he presented the symptoms usually seen in a case of asthma. He was distressed and

struggling for air; respiration labored, expiration very distinct and noisy. The heart rate was accelerated, but presented no signs of organic disease. He was ordered tincture of belladonna in ten drop doses with a little ammonia and subsequently ergot; and his chest was dry cupped. The prescriptions, all of which had for their line of thought the relief of spasm, were followed by great benefit. The breathing became better and easier, and he went to sleep. It looked as if all these antispasmodics had accomplished their work, and that the attack had passed away, when, about twelve hours after admission, during the night, he had a severe attack of dyspnœa with coughing, lasting about fifteen minutes, and, while the physician had gone for the laryngoscope, up came the piece of apple which I now show you. It is a little shrunken from the action of the alcohol in which it was placed for preservation, but it is still a piece of considerable size, longer than broad and irregular in shape. (It was about ⅞ of an inch in greatest length and about ½ by ⅝ in cross section.)

We then got this strange history that when the epileptic fit seized him he was eating an apple. During the convulsion this piece slipped from his mouth into his windpipe, and owing to the insensibility during the attack it was drawn into the trachea and lodged below the bifurcation, obstructing the left bronchus rather more than the right, and thus explaining the difficulty in breathing. He subsequently had a severe attack of dyspnœa in the middle of the night, in which he nearly died, and which was terminated by the expulsion of the foreign body. He has since had no signs of asthma; but was allowed to continue taking bromides, simply with the view of preventing the recurrence of the epileptic fits.

There are several points of clinical interest in this case. One of these is the way in which the symptoms of spasmodic asthma were closely simulated by the presence of this foreign body in the trachea lying at its bifurcation into the bronchi, which caused intense distress and labored respiration. But what was curious, he had also the physical signs of asthma; intense dyspnœa, noisy breathing, prolonged expiration, and weak inspiration; the percussion note was clear. There were no rales in the finer tubes; but, with this exception, he had all the symptoms which we would expect to find in a case of asthma.

Now what were these signs due to? A condition of spasm in the bronchial tubes. Therefore, if I say that it is like a case of spasmodic asthma, I may go further and state that this foreign body provoked an attack of asthma. There is almost identity of pathological condition.

Again, as bearing upon this view of the case, look at the results of treatment! They were most remarkable, and I might say most decisive. If it had not been for our getting the piece of apple, it would never have been supposed that a foreign body in the air-passages had caused the symptoms.

From the free use of belladonna and free cupping, there was most evident relief; the spasm, which had been evoked by this foreign body, yielded, and the patient breathed more easily and even went to sleep. Therefore the means employed largely removed the irritation, notwithstanding the cause remained.

Lastly, I may call your attention to this fact, that this foreign body had passed beyond the trachea, because if it had lodged in the wind-pipe, it would have given rise to much greater difficulty in breathing, and would have impaired his voice. As you heard in his history, his voice was distinct, but was feeble on account of his respiratory distress. So that in the violent convulsion which came on while he was eating the apple, this piece was inspired into the larynx, which, owing to the insensibility produced by the convulsive attack, allowed it to pass into the trachea, and into the left bronchus just at the bifurcation, where it caused irritation and set up spasmodic asthma, due to a foreign body.

At present his breathing is easy and natural. Upon auscultation, the inspiratory sounds are well marked on both the right and left side; nor is the expiration either prolonged or abnormal in character. The same condition is found posteriorly as anteriorly. The breath-sounds are not quite so strong at the lower part of the left lung anteriorly as at the corresponding part of the right lung. The percussion note is clear. The heart, which was feeble, has regained its tone. There is nothing abnormal.

His temperature is rather low. On admission it was 98.6° (F.), and it has since declined. This morning it is 96.4°; his usual evening temperature is 97.8°. Possibly the morning temperature may be lower on account of being taken after his ablutions, but the evening temperature is also low; since admission it has not exceeded 98°.

He has been taking twenty grains of

potassium bromide three times a day; but considering that he has this tendency to coldness, we will give him aromatic spirits of ammonia, half a drachm (f℥ss) three or four times daily. He shall also take exercise in the open air, and he shall have a nourishing but not too stimulating diet.

COMMUNICATIONS.

THREE REMARKABLE CASES OF REFLEX NEUROSES DUE TO EYE-STRAIN.

BY GEORGE M. GOULD, M.D.,
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There are some physicians who are at once seized with an acute attack of mental strabismus when they are told stories of peripheral irritation inducing functional disturbances, such as the following cases. The *superior oblique*, not the *internal rectus*, is the muscle affected. They distrust the Greeks even when bearing therapeutic gifts, and smile incredulously. For this reason I have hesitated to publish the notes of the following cases; but since the facts are well-known to several reputable physicians and may be substantiated at any time, and since, moreover, I believe all these cases range themselves under a common law that explains their apparent illogicality and makes them intelligible, I conclude it best to make them known to others.

Case I.—Chorea of Several Years' Duration Relieved at once by Correction of Ametropia.—Susie H., aged 14 years, came to me, Nov. 7, 1888, with the following history and complaints: Twitching of the right hand and foot was first noticed two or three years ago, coming on without noticeable cause. Since then up to this date she has been treated for chorea at one of our best Hospitals for Nervous Diseases. She gets somewhat better during summer, but when school again begins, she gets worse. Latterly, and just previous to coming to me, she had been having frontal headaches every day with attacks of giddiness or dizziness. Her mother and sister complain of her violent outbursts of temper. Sometimes, even in street-cars, and upon the slightest provocation she will burst out crying, or jump up and down and scream. The chorea, however, was the chief cause of complaint, and this seems to have continued during sleep, her sister being frequently disturbed or awakened by the jerking. The right shoe was worn out much sooner than the left, and as the child sat before me the motions of the hand and foot were continuous and painful to see. Menstruation began three months ago, but certainly had not made the chorea any better. In the history of the case I particularly noted that there had never been any blepharospasm or tic of the face. The child was physically a robust, well-built young woman, otherwise in excellent health, without a sign of hysteria, and whose parents were likewise of non-neurotic healthy temperament. When she came to me she was taking twelve drops of Fowler's solution three times a day, which had been ordered by the physicians of the hospital. The arsenic had no evident effect upon the disease and the order was to increase the dose until certain well-known symptoms were noted, or until she became sick from the effects. Under a mydriatic I ascertained her refractive error to be alike in both eyes, and corrected it by the following combination of lenses: Sph. + 1.00 D. = Cyl. + 0.75 D. Ax. 90°. Spectacles were prescribed and the arsenic treatment wholly and suddenly suspended. Instead of the choreic symptoms being thereby increased, her sister a week later told me that she was no longer troubled by the child's movements at night. In fact the involuntary movements of both foot and hand slowly disappeared, so that in three weeks after the application of glasses none were noticeable. The headaches, etc., have disappeared and the disposition changed for the better. So far as the chorea is concerned, it does not exist to-day.

Case II.—Flatulent Dyspepsia of 20 Years' Standing Cured by the Application of Spectacles.—On Nov. 11, 1888, Mrs. E. G., aged 44, was kindly recommended to me by her physician, Dr. O. P. Rex, who had after oft-repeated advice, finally got her to consult an oculist. Her complaint was of certain ocular and cerebral troubles, asthenopia, difficulty in near work, etc. She had had headaches for most of her life. She did not complain to me of her gastric troubles, naturally thinking these had no connection with an oculist's work. But inquiry soon elicited the information that her flatulent dyspepsia ("wind-colic," as she called it) was her greatest trouble, and that her life for at least 20 years had thereby been rendered most wretched. At once upon entering I noticed the constant eructations which were very unpleasant and continuous. The knowledge of the fact of the disgust excited in others, together with the disease itself had rendered her very

despondent and subject to melancholia. There were evident lassitude, prostration, a look of suffering in the countenance. She complained of a constant "load upon her stomach," and of loss of appetite, which last had been a great cause of weakness and debility. In the past 20 years she had had the services of several excellent physicians and had taken a great deal of many different medicines, all without relief. The least conversation with the woman showed the complete absence of any hysterical element. She had healthy parents, and had been a plucky, hard-working woman all her life, enduring and fighting her affliction with a heroism that few would under like circumstances have shown.

I was put upon the track of my diagnosis by the following fact: When I put her in position to examine her eyes with the ophthalmoscope, the unpleasant eructations were as usual constantly taking place; but, upon throwing the light from the mirror full into the eye, such an instantaneous and frightful paroxysmal attack took place that I hastily ran for a vessel, convinced that violent emesis was taking place. But it was only flatus. A repetition of the attempt had the same result, and I had to give it up; but the thought at once came to me that I now had to do with a reflex neurosis. To be brief: I found her refractive error indicated by the following combination: For Distance:— R., Sph. — 0.25 D., = Cyl. + 0.75 D. Ax. 110°; L., Sph. — 0.25 D., = Cyl. + 1.00 D. Ax. 70°. The presbyopic correction was Sph. + 1.50 D. added to the above. It was highly interesting to notice that the application of the distant glasses, in the trial-frame, as effectually quieted the gastric volcano as the ophthalmoscopic mirror had previously aroused it. So long as the lenses were in place, no eructations took place; the effect was so pleasant she was unwilling to have them removed, but when this finally became necessary the eructations instantly recommenced. On November 24, having procured and worn the prescribed glasses *ad interim*, my patient returned, saying she had had none of her old symptoms during the time she had worn the glasses. I remarked a look of zest and happiness in her face in marked contrast to that of her first visit. Her appetite had greatly improved, the "load" had disappeared from her stomach; she had had no "belching"; the headache and the lassitude had disappeared; she had been heard to sing at her work, and all her friends remarked the change in her appearance. She said she could not leave the glasses off a minute without trouble. Without apprising her, I fixed her gaze upon small distant letters, so to put the accommodation to a tension, and, while thus looking, I suddenly raised the glasses away from her face, and like a flash the eructations broke forth. I dropped the glasses, and they disappeared. Here was evidently as pure an example of neurotic reflex as one could wish. The improvement in health and the complete absence of gastric, cerebral, and psychological symptoms continues up to the present time.

Case III. — Cardiac Palpitation, etc., relieved by Correction of Astigmatism.—I am indebted for the following notes to the courtesy of Dr. A. P. Brubaker, of Philadelphia, and Dr. Lewis H. Taylor, of Wilkesbarre, Pa. The patient was referred to me by Dr. Brubaker, but could not stop in Philadelphia sufficiently long to undergo examination and treatment of the eyes, which were carried out by Dr. Taylor.

Mrs. J. N., aged 24, married, without children, had enjoyed good health until during the summer of 1887, when, following a great deal of reading at night, she was troubled with severe pain and burning sensations in the eyes. Shortly after this, she began noticing how rapidly her heart was beating, and this symptom increased until the heart's action numbered as high as 130 strokes a minute. Then began a decline in health, with loss of appetite, feeble digestion and nervousness. She soon lost something over 20 pounds in body-weight. When seen by Dr. Brubaker in the spring of 1888, the rapidity of the cardiac action was still as great as ever, and slight cardiac enlargement was noted. She was placed upon the tincture of aconite for several weeks, without deriving any benefit from it. I should have added that treatment by other physicians prior to consulting Dr. Brubaker had also proved ineffectual in relief of the palpitation. On June 12, 13, and 14 Dr. Taylor tested the refraction, etc., of her eyes under atropia, and prescribed, for constant use, the following glasses: R. Cyl.— 0.75 D. Ax. 180°, ⌒ Cyl. + 0.25 D. Ax. 90°; L. Cyl. — 0.75 D. Ax. 180°. Upon wearing the spectacles the rapid action of the heart began at once to subside, and within two or three months all the symptoms, ocular, cerebral and cardiac, had passed away, the heart's action had become entirely normal, the body had regained its entire loss of flesh, health, etc.

REMARKS.—To understand these cases and bring them under a common law we may be helped by likening the nervous system to the switch-board of a great telegraph-office. With every plug properly in place, every wire ends so that its messages are shunted to the proper table and operator and the out-going answers correspond to the call made. This corresponds to the physiological condition of the body when response is rightly co-ordinated to stimulus; when an outflow of saliva follows the placing of a sapid substance upon the tongue, when the capillaries expand by friction, when motion, secretion, etc., are the correspondent consequences of stimulus. If a careless or ignorant hand misplace a key of the telegraph switch-board there is chaos in the office, the messages do not reach the proper instruments, and replies are sent to the wrong far-away stations. Reflex neuroses are precisely such results in the body: the return messages do not reach the point of irritation, but some non-irritated organ which must then vicariously suffer for the sins of another.

Those who reluctantly admit the possibility of reflex neuroses, say that they cannot take place unless intermediated by centers in topographical proximity. They would say, for example, that an irritational strain of the oculo-motor could not result in choreic discharges from the phrenic or pneumogastric or cardiac centers, because of the distance of the "jump" or transfer. But may it not be that distance has little or nothing to do with the matter? This is not a saltation of the electric spark across a blank or insulated space. The number of associate fibers between centers is of course proportional to the functional relations of their peripherally located co-related mechanisms: but no center is wholly disconnected from any other, though the fact may not be anatomically demonstrated. The brain is certainly an organic unity and this is only possible by the means of myriads of commissural fibers proceeding almost everywhither and binding all ganglia together directly or indirectly. It is well established that chorea of the extremities may be caused by phimosis or other genital derangement, by a carious or impacted tooth, etc., etc., and yet the Rolandic centers are far-removed from those of the other organs. In place of topographical proximity, may there not be another law having a much more dominant power, that is, the law, or a corollary of the law, of the conservation of energy? Every irritational stimulus that from a peripheral organ proceeds inward may be viewed primarily in its dynamic aspect: it is force, and its function is to bring about another discharge of force whose nature and outgoing should correspond to the want indicated by the stimulus. If it is so correspondent, it is physiological; if it is not so, it is pathological, it is a reflex neurosis. But again this derouted discharge is also subject to the law that it must follow along the line of least resistance, and in accordance with this, its outlet will lead to those muscles and functions most easily moved. In irritational choreas the hand or foot or other small muscles are the most frequently set in motion. May it not be that sometimes when these channels become too small to drain off the overflow, other and greater centers are inundated, and that chorea thereby may even pass over into epilepsy? When slight irritational stimuli do not find such outlets, a general irritability and motility give vent and relief: a man with the toothache will walk the floor, a boy with "acute indigestion" will writhe and dance, a girl with eye-strain is restless and inattentive, etc. This overflow of unutilizable stimulus may according to peculiarities or habits become a tic, a strange habit of gesture, a chorea of the extremities, or, as it seems may have been true in my cases, what might analogically be called a chorea of the diaphragm, or a chorea of the cardiac muscle. But, whatever the explanation, such cases overlooked every day are doubtless more frequent than we suspect. This must be true when we think of the growing complexity of strain and nervous disease consequent upon our high-pressure civilization. Such derouta-tion and irregularity of outflow cannot help constituting in the future a prolific source of pathologic facts,—but a no less fertile source of brilliant therapeutics for the intuition and art sufficiently subtile and far-seeing to track out the hidden and distant *fons et origo mali*.

There can be no doubt that eye-strain is far above all others the one preponderant source of irritational neuroses. The incredulous smile at the hobby-riding specialist must give way to facts and the logic of facts. Here is a mechanism the most delicate, and moved by the slightest forces, of any in the organism; it is the most complexly constructed of all, its function the most important of all and the most used of all; its nuclear associations are the most wide, intimate and direct with all other centers, and every process of thought or

emotion is inextricably bound up with its functions and memories; language and intellect may be justly considered its products. And yet with all this, it must be remembered that within one or two centuries this wonderful mechanism is put to a strain for which it was never planned and to which in its evolution or history it has never been subjected. I allude, of course, to the persistent exercise at near range that is the necessary outcome of the art of printing, of schools, of commercialism, of urban life—in a word, of nineteenth century civilization. The natural eye is hyperopic and nature so forms it now. Ocular disease is growing as fast or faster than civilization. The sudden strain does not give time for the adaptation, even if one of these adaptations, myopia, be not a disease itself. If the naturally hyperopic eye, with nature's customary obstinacy persist in its hyperopia, and if in addition, corneal asymmetry (astigmatism) be superadded, even muscular insufficiency—then there can be but one result of the forced work at short range to which every servant of civilization is subjected. Unless every ametropic child have its ametropia corrected, either ocular disease, cerebral disease or reflex neurosis must ensue. This seems a certain result of the law of the conservation and equivalence of force. Pathology is but disordered, unregulated physics and physiology. In fact, the ophthalmic surgeon has not ridden his hobby half hard enough. He has been frightened by a sneer. If held "well in hand," his horse will not soon be winded. My own limited experience has convinced me that many general physicians are strangely obstinate in ignoring ocular strain, for years drugging their patients with bromides, iron and tonics, for cerebral or gastric derangements that disappear as if by magic when the eye-strain is relieved. Cases of tragic suffering due to such mistaken diagnoses are constantly turning up.

The cases I have described are all examples. Even where eye-strain is acknowledged to cause such neuroses, it is thought that several dioptres are necessary to set up the trouble. On the contrary, I have had cases where one-half and even one-fourth of one diopter is quite sufficient. Neither can such quantities be diagnosticated by the ophthalmoscope. To me the report from a hasty ophthalmoscopic examination that no eye-strain exists, is *per se* an evidence either of ignorance, or carelessness, or worse.

I have intimated that in my view the three cases described are essentially alike in cause and method of production: the chorea proper, the flatulent dyspepsia and the cardiac neurosis were all due to a peripheral irritation, eye-strain, that, derouted in its reflex course, returned somehow, directly or indirectly to other organs than to those concerned in the irritational stimulus. For other illustrations of this proceeding, see the excellent article of Professor Brubaker, *The Reflex Neuroses of Dental Pathology* in Lea's American System of Dentistry. There is no logical reason for limiting the term chorea to certain muscles, and a chorea of the diaphragm or of the heart muscle may prove as scientifically justified as one of the hand or foot.

As regards the details of the cases cited there is little to be objected to in the first case. It was a typical case of chorea, wholly uninfluenced by arsenic, and yielding quickly and completely when the irritational strain was removed. It may be said of the second case that too much is proved, because the 20 years of functional derangement must inevitably have set up organic changes that would not disappear in a day. I can only answer that the most brutal fact is worth more than the most beautiful theory; that the case is accurately reported; that a study of the symptoms, etc., seemed to show me that the gastric derangement was not due to imperfect secretion, was not chemical or organic, but was due to a spasmodic action of the diaphragm or of the muscular walls of the stomach. The fact, however, may bear other explanations, which I leave to others to give. As to the third case it may be true that the cardiac acceleration was due to a stoppage of the normal inhibition of its rhythm, and not to a positive increase of its innervation. In this case the force of the derouted reflex would find its own force neutralized in overcoming the cerebral inhibition.

—The *Ledger* says that Dr. Weisbach has been making careful measurements of the skulls of Beethoven and Schubert for the Vienna Anthropological Society. In his report he says that Schubert's skull, compared with measurements taken of 30 German-Austrian skulls, is slightly larger, longer and broader, but also somewhat flatter, than the average. Compared with Schubert's, Beethoven's face was altogether smaller, and much narrower between the cheek-bones, and especially about the lower jaw.

TECHNIQUE OF ABDOMINAL PALPATION.[1]

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The following paper has been prepared as an addition to that on the "Value of External Examination in Obstetric Practice," which was presented to the Association September 26th, 1888, and published in the REPORTER, Oct. 20, p. 488. The request of some of the members is my excuse for bringing before you a brief and incomplete account of the technique of abdominal palpation—a subject which has been so ably presented to the profession by others, notably by Pinard. The subject of abdominal palpation as applied to the diagnosis of the presentation and position of the fœtus *in utero* only, will be considered.

Before proceeding to discuss the subject proper it will be well to recall certain physiological and mechanical facts which serve to render the results of palpation more exact, and at the same time more easy to attain.

It is now certainly known that while the head, breech or lateral plane of the fœtus may *offer* at the superior strait prior to labor, the vertex alone *engages*. The pains of labor are necessary to cause the engagement of the other presentations. The reason why only the vertex engages prior to labor is that the diameters of the vertex alone bear such a relation to the diameters of the pelvis as to make engagement possible, without the moulding effect of labor. It is also known that the head engages in a state of flexion—in obedience to the same law of accommodation which governs the attitude of the fœtus during pregnancy, and the imparted movements of the presenting part during labor. The knowledge of these two facts—that prior to labor, of the various possible presentations only the vertex engages, and that it engages in a state of flexion—is of immense importance in practising palpation. When the pelvic excavation is found full, that is, when the presenting part has engaged, we are at once assured that the vertex is presenting.

Since the vertex engages in a state of flexion, the occiput descends more deeply into the pelvis than the brow, and hence the brow is more accessible to the hand palpating from the abdomen; or, in other words, when the two hands palpate the abdomen above the occiput and the brow, if both hands are depressed, the hand corresponding to the occiput will sink more deeply into the pelvis, before it is arrested by the resisting occiput, than will the one corresponding to the brow. A further point to aid in the differentiation is that the brow feels harder to the touch than the occiput does. This may be owing to the relative thinness of that part of the scalp which covers the brow, when contrasted with that which covers the occiput, or it may be due to the more advanced degree of ossification of the frontal bosses as compared with those of the occiput; or, again, it may be that the greater accessibility of the brow makes it feel harder to the examining finger. I am inclined to believe that all three factors unite to create the difference in sensation imparted by touch. By thus discriminating between the brow and occiput, the position is determined.

It is important to know that the difference in the character of the articulations between the head and neck and the breech and trunk assists in differentiating between breech and head presentations in some cases. This differentiation is based on the wide range of mobility of the head, and the limited range of mobility of the breech. The head can be moved widely without disturbing the trunk, but it is not possible to move the breech independently of the trunk. Owing to these anatomical peculiarities the head can be ballotted, but the breech cannot. This cephalic *ballottement* can be obtained in head presentations (prior to engagement), in breech, and also in trunk presentations.

The thorough appreciation of these facts is of the greatest assistance in palpation. The practice, then, is based upon scientific data, and the method is rendered systematic and very uniform in its results.

The dress and position of the woman to be examined by abdominal palpation, are by no means matters of indifference. The less clothing worn, the better. Hence it is best to examine the patient in bed, and to see that she is clad only in her night-dress. When the skirts are simply pushed down below the nates, and the upper garments drawn up, to expose the abdomen, especially if corsets are worn, so much discomfort is caused that respiration is more or less disturbed, resulting in quickened respiration, which embarrasses the examiner.

The woman should occupy the dorsal decubitus, with the arms along the sides,

[1] Read before the Northern Medical Association, Dec. 14, 1888.

the thighs and legs extended, and the legs slightly separated. This allows the examiner to explore the false pelvis with ease, and the pelvic inlet with considerable facility. This position, which is that insisted on by Pinard, alone enables the examiner to explore the pelvic cavity. When the thighs are flexed upon the abdomen, and the legs on the thighs, the hypogastric region is so encroached upon by the thighs as seriously to embarrass the examiner in his manipulations, and even to prevent absolutely a satisfactory exploration of the pelvic cavity. The decubitus should be as nearly horizontal as possible—only a low pillow should be placed under the head. Occupying the horizontal decubitus, the woman has little temptation to contract the abdominal muscles, because no *point d'appui* is provided.

The bowels, and especially the bladder, should be emptied before beginning palpation. When the bladder is full the presenting part is inaccessible, and the sensations perceived are indefinite and untrustworthy.

The temperature of the room in which the examination is made should be such as not to chill the patient, who must lie with her bared abdomen exposed for some minutes.

The examiner's hands should be warm. It is well to wash the hands in warm water not only to secure the necessary warmth, but also to render the tactile perception more acute. Should palpation be attempted with cold hands, disappointment will surely result. The reflex contraction of the abdominal muscles from cold is prompt, and sometimes the shock causes the uterus to contract also—painless contraction of pregnancy.

Palpation can be practised only in the intervals between the contractions of the uterus; hence, when a contraction occurs during the examination, exploration must cease until this passes off. In practice this time can be usefully employed in listening to the fœtal heart-sounds, the location of which is of value in diagnosis, and the recognition of which establishes the fact that the fœtus is living.

While not strictly *apropos*, it is not unimportant to observe that the frequent recognition by the practitioner of these painless uterine contractions of pregnancy, during the routine examination of pregnant women, will effectually prevent such glaring errors in diagnosis as have occurred in the past, and are occurring even now. Were obstetric palpation generally practised, the pregnant womb would never be mistaken for a neoplasm, and unpremeditated Cæsarean sections would cease to occur.

With the foregoing principles in mind, and the conditions insisted on having been complied with, the examiner stands indifferently to the right or left of the woman, who is placed on a hard mattress sufficiently near the edge of the bed to be within easy reach. It is well to stand about opposite the umbilicus. Palpation is begun by estimating the thickness of the abdominal wall. This is done by picking up a fold between the thumb and fingers. The diagnosis of pregnancy having been established, it remains to determine the presentation and position of the fœtus. I have found it best to follow the teaching of Pinard, who examines after a uniform method, taking the bony pelvis of the woman as a fixed land mark. The horizontal rami of the pubes are sought for, and the hands, separated four or five inches, are placed upon the abdomen, the finger tips resting upon the upper margin of the pubic rami. This is easy under ordinary conditions, but when the abdomen is pendulous it is necessary first to raise up the sagging abdomen with the palms, before proceeding as indicated. The abdominal wall is then depressed from above downward and from before backward, the finger tips just grazing the pubic rami. The inlet of the true pelvis is thus explored and one of two conditions is found—that the cavity is *full* or that it is *empty*.

When palpation is practised in the last six weeks or two months of pregnancy, in the immense majority of cases the pelvic cavity is found full, the presenting part has engaged. Thus the diagnosis of vertex presentation is usually readily made. The presenting part is felt to be round, regular, and resisting. The head may be deeply engaged—and usually is in primiparæ—and immovable; slightly engaged and movable in the pelvic inlet; or it may simply rest at the pelvic inlet. When the head is found well engaged not only is the diagnosis of the presentation determined, but also that a proper relation exists between the diameters of the pelvic inlet and those of the fœtal skull. This condition is of prognostic as well as of diagnostic importance. Moreover, it is known that the presentation is fixed and definite—the uterine, fœtal, and pelvic axes coincide, accommodation is complete, and change of presentation impossible; only change of position can occur.

The diagnosis of the position is made by finding upon which side the cephalic tumor

is more accessible. This is determined by depressing the abdominal wall by the two hands, in the manner already described, until the palpating hands are resisted by the cephalic tumor. The hand upon one side will descend more or less deeply into the pelvic cavity, while that upon the other side will be arrested at a higher point. That portion of the head which is more prominent and accessible is the brow. These points are most easily determined in primiparæ, because in primiparæ engagement is more complete than in multiparæ—the vertex sinks into the pelvis, carrying the inferior segment of the uterus before it, at times almost to the pelvic floor; in which case flexion is very marked, and the different level occupied by the brow and occiput is easily determined.

When engagement is not so marked, as in the occipito-posterior positions, flexion is not so great, and the differentiation is correspondingly difficult to make. In my experience it has been at times impossible to say that the cephalic tumor was more accessible upon one side than upon the other, and I have been obliged to rely on other signs for the diagnosis of the position.

To sum up, then, when the pelvic cavity is full, the vertex is presenting. If the cephalic tumor is more accessible to the right, the position is left, and *vice versâ*.

Having explored the region of the superior strait and recognized the depending fœtal head, it remains to examine for the trunk, breech and extremities of the fœtus. Pinard recommends that the breech be searched for in the region of the fundus uteri, but I have usually proceeded to examine the uterine contents systematically, from below upward. In many cases it is possible distinctly to define the groove between the head and shoulders. Passing upward, palpating gently with the finger tips, upon one side at a time, a resisting plane, more or less broad, can be made out; this corresponds to one lateral half of the uterus. The fingers meet with little resistance in the other lateral half of the uterus. The abdominal and uterine walls can be more or less deeply depressed. Usually in making these manipulations the fœtal small parts can be felt. If the resisting plane is broad, it is the fœtal dorsal region; if not so broad, it is the lateral plane of the fœtus. In the one case the occiput is anterior, in the other it is posterior. Again, if the small parts are very accessible, that is, if they are anterior, the position is posterior; while if the small parts are accessible with difficulty, that is if they lie posterior in the uterus, the position is anterior. Should the fœtal dorsal region or lateral plane be separated from the uterine wall by liquor amnii, and not be easily reached by palpation, the manœuvre of Budin, which consists in depressing the breech—that is, increasing the natural anterior curvature of the fœtus—is useful. By this means the fœtal dorsal or lateral region is brought in contact with the uterine wall, and is then easily examined by palpation.

In head presentations the breech is found in the fundus uteri, in one or other hypochondriac region. The breech is best found by following upward the resisting plane of the fœtus (dorsal region, or lateral plane), which begins at the shoulder below and ends at the breech above. The breech gives the sensation of a voluminous, irregular body, less resisting than the head. The fœtal small parts are often felt in close proximity. The breech has not such a characteristic "feel" as the head.

Palpation after the method described usually gives positive results. When the sensations felt are typical, a diagnosis can be made of single pregnancy, of the presentation and position of the fœtus, and that pregnancy is not complicated by large intra-uterine or extra-uterine tumors. Cases of the class just considered form the immense majority of those seen in practice.

Instead of finding the pelvic cavity full, however, the palpating hands may find it empty. In this case, the lower end of the fœtal ovoid is usually found in one of the iliac fossæ, or it may be found resting on the pelvic brim, or above the plane of the superior strait. Almost never do the two extremities of the fœtal ovoid occupy the opposite flanks. Since one extremity of the fœtal ovoid is always in relation with the false pelvis, this region should be explored first. Whether the head or breech occupies the inferior uterine segment can be determined usually by recognizing the proper characters of these parts; and by finding the opposite extremity of the fœtal ovoid and the back, the exact location of the fœtus can be determined. If it is not possible to differentiate between the head and breech by recognizing the characters proper to each part, nor to locate the furrow between the head and shoulders, the head can be distinguished from the breech by a resort to *ballottement*. The head can be ballotted, but the breech cannot. As already pointed out, this fact is due largely

to the different character of the connection between the head and trunk and the breech and lumbar region. It is due partly to the fact that the head is spheroidal in shape, and hence touches the uterine parietes at one point only, while the breech is in contact with the wall of the uterus by an extended surface.

It seems to me that it will be sufficient to give the diagnostic signs of the first and third positions of presentation of the vertex, and to refer briefly to the other presentations and positions.

Presentation of the Vertex: First Position.—The patient having been placed in the proper position for palpation, and the conditions which promote success having been complied with, the examiner begins to palpate. The thickness of the abdominal wall is estimated by picking up a fold between the thumb and fingers. The horizontal rami of the pubes are then found, and the hands, separated four or five inches, are placed upon the abdomen, the finger tips resting on the rami of the pubes. The abdominal wall is depressed from before backward and from above downward, which allows the inlet of the pelvis to be explored by the finger tips. Usually the cavity of the pelvis is found full—occupied by a round, regular, resisting body, which can be nothing but the engaged head. This being determined, the hands are placed at a slightly higher level (nearer the umbilicus) and depressed as before, to discover which side of the cephalic tumor is more accessible. This side corresponds to the brow, the other to the occiput. In the first position of the vertex presentation, the brow is found to the right. The diagnosis of this presentation and position is made usually in this way very readily. The diagnosis is confirmed by further palpation, or, should the diagnosis of the position be doubtful at this point, it can be made by finding the location of the back, small parts and fœtal heart sounds.

The examination is continued by palpating the abdominal contents systematically, from below upward, making light pressure with the finger tips, first on one side, then on the other. A broad resisting plane will be found, in the first position, in the left half of the uterine cavity; while the fingers will sink deeply on the right side, depressing the abdominal and uterine walls. The plane which resists the fingers is the fœtal dorsal region. Resistance is not felt on the right side because the liquor amnii, which occupies the space between the curled-up body of the fœtus and the uterine wall, is readily displaceable. The breech is found continuous with the "resisting plane." In primiparæ, and in multiparæ with tense abdominal muscles, the breech is found usually in the left hypochondriac region, while in women with lax abdominal and uterine walls it is more likely to be found in the epigastric or right hypochondriac regions. Owing to the anterior position of the dorsum, the small parts are posterior and relatively inaccessible. (In practice, the diagnosis is confirmed by finding that the fœtal heart-sounds can be heard plainest to the left of the median line at a point about halfway between the umbilicus and the middle of Poupart's ligament.) Thus it is seen that the diagnosis does not depend upon the recognition of any one point, but upon the determination of the location of the various anatomical regions of the fœtus; and for this reason the diagnosis is very reliable.

In case the vertex has not engaged it is of little importance to determine the position of the fœtus, since under these circumstances the position is very unstable. It can be done, if desired, by locating the back, and fœtal small parts.

Second Position.—This position is very seldom encountered. The description of the diagnosis of the first position is applicable to that of the second position if the words "right" and "left" are transposed.

Third Position.—Owing to the less degree of flexion of the head in posterior positions the relative accessibility of the brow is not so marked as in anterior positions; hence the results gained are not so definite. Usually, however, it can be determined that the position is right by finding the brow to the left. This is confirmed by finding a resisting plane in the right side of the uterus, and by the absence of a resisting plane on the opposite side. The resisting plane, felt to the right is narrow—it is the lateral wall of the fœtus. The small parts are anterior and can be readily felt in the left side of the uterus The breech will be found in the right hypochondriac, epigastric, or left hypochondriac regions, according as the abdominal and uterine walls are tense or lax. (The fœtal heart is heard plainest far to the right of the median line.)

Fourth Position.—The description of the diagnosis of the third position is applicable to the fourth position, the words "left" and "right" being transposed.

Presentation of the Breech.—The pelvic cavity is found empty. The breech is found in relation with the false pelvis. If it be impossible to recognize the breech

by its proper characters the diagnosis can be made by finding the head at the fundus uteri. (The fœtal heart is heard at or above a horizontal line dividing the uterus into two equal parts.) The position is made out by locating the dorsum and fœtal small parts.

Presentation of the Trunk.—The pelvis is found empty. The long axis of the uterus is oblique and not parallel with the long axis of the body. One extremity of the fœtal ovoid is found in one iliac fossa and the other in the opposite flank. The dorsum or fœtal small parts are felt in relation with the anterior wall of the uterus. Pinard found the head in one flank and the breech in the other only twice in the 100,000 women examined by him.

Presentation of the Face.—It is practically certain that presentation of the face never occurs prior to labor. Those who have examined women per vaginam only, admit that primitive face presentations are exceedingly rare. Naturally these examinations have seldom been made until the advent of labor. The fact that Pinard has never met with a face presentation prior to labor is strong evidence that this presentation is produced after labor has set in.

The description of presentations of the vertex already given was restricted to women with normal proportions. Pinard states that in women having pendulous bellies (ante-version of the pregnant uterus) a special accommodation is found. The occiput is in relation with the middle of the iliac bone, and not with either the acetabulum or the sacro-iliac synchondrosis. The breech is found near the ilium opposite to the occiput, and the feet are felt very near the brow. That is, the fœtus is very much curved on itself, and a considerable part of the dorsum runs transversely across the uterus, instead of approximately parallel with its vertical diameter. A resisting plane is felt on each side of the uterus, and the elasticity of the liquor amnii is perceived as easily above as below. Unless this peculiar accommodation of the fœtus is known, a mistake in diagnosis is easy.

When the vertex presents in women whose pelves are deformed by rachitis (rickety flat pelvis) the head is found at the level of the superior strait or slightly engaged—depending on the degree of contraction. As is well known in this variety of contracted pelvis, the long, *antero-posterior*, diameter of the head is parallel with the long, *transverse*, diameter of the pelvis. Flexion is slight. The brow can sometimes be felt at a higher level than the occiput, and at times can be recognized by its marked hardness. The dorsum is felt in relation with one lateral wall of the uterus, the narrow lateral plane of the fœtus being directed anterior. The breech is found in the fundus when the uterus is not anteverted. The small parts are felt in the lateral half of the uterus opposite the dorsum.

In the other varieties of contracted pelvis, when the degree of contraction is at all great, the head rests at the level of the superior strait, and is freely movable by the palpating hands. It is impossible to force the head down into the cavity of the pelvis, *i. e.*, to make it engage, by making pressure from above. The same is true in cases in which the disproportion between the head and pelvis is due to abnormally large size of the head, as from hydrocephalus, being especially marked when the disproportion is great.

ERYSIPELAS OF THE PHARYNX AND FACE.

BY EDWARD P. DAVIS, A.M., M.D.,

OBSTETRICIAN TO THE PHILADELPHIA HOSPITAL; PHYSICIAN TO THE FOULKE AND LONG ORPHANAGE FOR GIRLS, AND TO THE CLINTON ST. BOARDING HOME FOR WOMEN, ETC.

The following case, while not rare, furnishes a clinical study of practical interest:

R. F., 17½ years old, a robust girl of full development, had formerly had diphtheria and scarlatina. Examination of the pharynx, when in ordinary health, revealed slightly enlarged tonsils with chronic catarrh of moderate severity of the pharynx and posterior nares. She had, at intervals of 6 or 8 months, several attacks of tonsillitis from which she recovered under the use of sodium salicylate, and a gargle of boracic acid, potassium chlorate and glycerine. On Dec. 14, 1888, the writer's attention was directed to the patient who was said to be suffering from "a cold," contracted 48 hours previous. The face was flushed, the pharynx uniformly reddened and swollen, the tonsils enlarged: moderate constitutional disturbance was present. As the symptoms were those of previous attacks of tonsillitis treatment for that condition was ordered.

Twenty-four hours later the nature of the infection from which the patient suffered was apparent. The face exhibited the diffuse lymphangitis present in facial erysipelas; the pharynx was intensely reddened, uniformly swollen, without membrane; the

tonsils swollen, but not greatly in excess of the swelling of the surrounding parts. The lymphatic glands of the neck were enlarged and tender. A marked febrile disturbance existed, with severe frontal headache, backache, pains in the limbs and photophobia. The diagnosis of erysipelas of the pharynx and face, originating in a septic focus in one or both tonsils, was made. The subsequent history of the case confirmed the diagnosis. The temperature on the second afternoon rose to 105° F., and gradually declined to normal on the 14th day. The pulse ranged from 120 to normal; respirations from 30 to normal. Mild delirium, alternating with stupor, persisted for several days. The infection of the lymphatics extended over the nasal and pharyngeal mucous membrane, but did not invade the larynx; bronchitis of the larger tubes was present, but the parenchyma of the lungs was not infected. The mucous membrane of the gastro-intestinal tract shared in the infection, and gastric and abdominal pain, tenderness and distension were present. On the face the lymphangitis invaded the scalp; on the neck and trunk it extended slightly below the clavicle, over one shoulder. At no time was membrane present in the throat; the follicles of the tonsils were distended by sero-purulent fluid, and the mucous membrane of the pharynx became grayish and infiltrated with similar fluid.

As the attack declined in severity desquamation occurred on the face, and in the pharynx and nares. The patient expectorated and ejected from the nose a mucopurulent fluid, which left the surface of the mucous membrane a bright pink. The stools were voided with pain and difficulty, and were streaked with mucous and grumous coffee-ground material. A slight urethral and vaginal discharge was also present. Convalescence was established at the end of three weeks.

The treatment consisted in the regular and persistent administration by a competent nurse, of whiskey and milk, the amount of alcohol given varying with the pulse and temperature, as indicating the severity of the septic intoxication. High temperature was treated by sponging with alcohol and water; no antipyretics were given. Suppositories of glycerine were used to relieve constipation, and soap and water enemata were occasionally employed. Boracic acid was used as a local antiseptic; the conjunctivæ were douched with a saturated solution diluted one third; the pharynx was treated with a saturated solution in glycerine, employed as a gargle; the nares were thoroughly douched with a glycerine and water solution. An ointment:

Acid. boracic. pulv.	ʒi
Lanolin	ʒi
Vaseline	q. s.

was thoroughly employed in anointing the lips, nostrils and abraded surfaces on the face.[1]

Alcohol was the only constitutional antiseptic and cerebral sedative given; the quantity administered varied with the indications and effect desired. As the fever declined a mercurial purge was given, followed by salines. The urine was rich in urates and phosphates, with a trace of albumin. Easily digested food was allowed in abundance as soon as the condition of the intestines warranted its administration. The case was considered infectious and contagious, and was isolated: the apartments occupied were thoroughly fumigated and disinfected after the patient's convalescence: the patient received an antiseptic (carbolic acid) bath, and especial attention was given to cleansing and disinfecting the scalp and hair.

The point of practical interest to which attention is directed is the centre for septic infection afforded by an enlarged tonsil. In the case in question no caries of the teeth or jaw and no ozæna existed in which the infection could have originated.

It has been shown by numerous observers that "catching cold" is not an adequate cause of erysipelas of the face; while exposure to cold may cause congestion, predisposing to inflammation, yet the specific germ of septic infection is needed to produce erysipelas. Tissues in which necrosis of the cellular elements has occurred furnish a peculiarly favorable culture field for such infective micrococci. This has been especially well shown by Kaposi,[2] who considers the most frequent sources of facial erysipelas to be a carious tooth; a patch of facial eczema; lupus; scrofula or syphilis of the nose, or retro-pharyngeal abscess. Strümpell[3] regards nasal catarrh, acute or chronic, as a common predisposing cause of facial erysipelas. Koch and Fehleisen have shown

[1] Some samples of lanolin are too stiff for a convenient ointment, and can be mixed to advantage with vaseline or cosmoline.

[2] Pathologie und Therapie der Hautkrankheiten Erste Hälfte. 1886. § 406.

[3] Lehrbuch der Specieller Pathologie und Therapie der innerer Krankheiten. Erster Band, 1886. § 95.

the possibility of direct infection and contagion when the infective germ finds a favorable culture-field. It is for this reason that persons whose nasal and pharyngeal mucous membrane and cutaneous surfaces are intact may come in contact with erysipelas with impunity, while another who possesses a focus of former suppuration is readily infected. As the patient was in an institution in which other inmates were living who had formerly had tonsillitis or other inflammatory affections of the pharynx, jaws or nares, her isolation was necessary.

Regarding the treatment of such a septic infection, the value of alcohol is especially noteworthy, when combined with easily digested food. No other antiseptic can be introduced into the blood in efficient quantities without danger to the patient. The use of antipyretics which act by depressing the nervous system is contra-indicated in septic fever; in the present state of knowledge of pathology it is not known that fever is not a conservative process by which the spores of septic cocci are destroyed as soon as formed.[1] An antiseptic which can circulate in the blood, destroying septic germs, and in proportion to the dose exciting or exercising a sedative influence upon the cerebro-spinal centres, is needed in the treatment of septic fever. Among other objections to the depressing antipyretics is the fact that secretion and excretion are impaired by their use in large doses. In this connection Runge's method of treating puerperal septicæmia by alcoholics, baths and packs and forced feeding is instructive; his cases now number 20, with 15 recoveries.[2]

The local treatment of facial erysipelas is important, as Kaposi has shown. The mouth, pharynx, nares, and ears should be thoroughly cleansed and disinfected by an innocuous antiseptic, iodoform, thymol or boric acid.

A vaseline or lanolin ointment containing one of these antiseptics may be employed to advantage in carefully healing fissures or abrasions on mucous membranes or skin.

Erysipelas, or infection of the mucous surfaces of the body by Fehleisen's micrococcus, is sufficiently common to afford abundant opportunity for its clinical study, and with other septic infections offers some of the most interesting problems in modern pathology.

[1] Welch; Pathology of Fever; *Medical News*, May 26, 1888, p. 568.

[2] *Archiv für Gynäkologie*, Band 33, Heft 1.

A FORMULA FOR CROUP.

BY J. B. JOHNSON, M.D.,
WASHINGTON, D. C.

The following formula has been a standard prescription of mine for croup for many years. It relieves all the symptoms of the disease with greater promptness and certainty than any other mixture I have ever used. I give it in teaspoonful doses to infants six or eight months old; and to children six and eight years old I give dessertspoonful doses every ten or fifteen minutes, until free emesis is produced; I also use it at longer intervals until a cure is established. The formula is as follows:

℞ Misturæ Acaciæ . . . . . f℥ij
Balsam. Copaibæ . . . . . f℥j
Ext. Ipecac. Fl. . . . . f℥j
Potassii Iodidi . . . . . ℥j
Pulv. Potassii Chlorati . . . . . ℥j

M. S. Shake well. Dose, a teaspoonful every ten or fifteen minutes until free vomiting ensues; and then continue the same dose, at intervals of a half-hour or hour, until the disease yields.

I have frequently relieved a croupy cough of twelve hours' duration, in three or four hours, by giving tablespoonful doses, every quarter or half-hour, of the following mixture:

℞ Potassii Iodidi . . . . . ℥j
Pulv. Potassii Chlorati . . . . . ℥j
Aquæ distill. . . . . f℥vj

M. S. Shake well and give a tablespoonful every quarter or half-hour until relief is attained.

—The *Boston Med. and Surg. Journal*, Jan. 17, 1889, says that the German societies of Brooklyn, N. Y., interested in the establishment of a German hospital, have appropriated about $10,000 from the regular society fund to the purchase of a hospital site in the 18th ward, near the routes of the Brooklyn Elevated and other city railroads. The twenty-seven parcels of land bought aggregate 50,000 feet or more.

—The *Western Druggist*, Jan., 1889, says that quinine, under a recent decision of the Illinois Supreme Court, is not a "domestic remedy" and cannot be sold except by a registered pharmacist. An Illiopolis barkeeper has been recently fined for selling it. In view of the late crusade of saloon-keepers against alleged dramselling-druggists, the compliment should be returned by prosecuting quinine-selling liquor dealers. Absinthe is also a drug, and an attempt might be made to suppress its sale also.

SOCIETY REPORTS.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, January 28, 1889.

The President, A. S. HUNTER, M.D., in the Chair.

DR. H. D. CHAPIN read a paper on

Septic Poisoning in Early Life.

Cases of septic poisoning in early life, he said, are conveniently divided into those which occur in the newly born and those which occur in older infants. In the newly born the seat of entrance of the poison is usually the umbilicus, and may, according to J. Lewis Smith, be by way of the vein or by way of the lymphatics. The abrasion giving entrance to the poison may be caused by the forceps; after birth and after healing of the cord, the genitals are likely to be the vulnerable point. The infection often starts as an erysipelatous inflammation upon the surface, and some poison enters the system, giving rise to inflammation of the peritoneum and other serous membranes, etc. In older children the upper part of the body, especially the scalp, mouth, etc., become the vulnerable parts. Pediculi, which cause the child to scratch and thus introduce matter from ulcers into the system, are not infrequently the cause. The germs when introduced in small quantity may be entirely or largely disposed of by the inherent vitality of the lymphatics, and cause only local symptoms; but if introduced in larger numbers constitutional symptoms develop. Dr. Chapin thinks aphthous mouth with small ulcers may be the source of septic poisoning, as also may otitis media purulenta, etc. In closely crowded apartments with imperfect ventilation, sewer-gas and foul air, the germs are constantly brought in contact with the air passages, and doubtless often give rise to mild forms of septic poisoning, which are commonly attributed to malaria.

The treatment should be prophylactic; but when septic poisoning has occurred, the seat of entrance of the poison should be sought for, cleansed, and healed, and, in addition, general measures are indicated.

DR. J. LEWIS SMITH thought the severest cases of septic poisoning in infants took place at the umbilicus. He suggested filling the umbilical fossa with iodoform in the newly born. He believes scarlet fever and diphtheria often prove severe or fatal on account of septic material finding entrance at the seat of lesions occurring in those diseases. Strict cleanliness and antisepsis should be observed. Vapor of carbolic acid, turpentine, and eucalyptus (the latter to mask disagreeable odor) should fill the room; and a spray of bichloride of mercury, in quantity sufficient for an internal dose, should be used in diphtheria, allowing it to pass on down the throat.

DR. A. H. SMITH urged the importance of stripping gelatinous material from the cord and thus hastening mummification.

DR. SIMON BARUCH read a paper on

The Value of Water in Therapeutics,

in which he sought to give an impartial review of its value as established by clinical evidence, and not simply to praise the water-cure system. During his service as army surgeon in the late war it was the custom to use water freely in dressing wounds, and the mortality from suppuration and gangrene was greater than has attended the more recent dry dressing. In laparotomy boiled water has been demonstrated to be of value. It is the author's belief that the antiseptics of the surgery of the future will be largely cleanliness, obtained by boiled water, and not so much by antiseptic drugs. The value of hot water as a styptic has been established; it is especially serviceable in *post-partum* hemorrhage. The marked value of vaginal douches in certain inflammatory conditions has been established by Dr. Emmet. Water is of benefit also in certain skin affections, but is contraindicated in eczema. The treatment of otitis media purulenta by irrigation has been abandoned for the dry treatment, and with great advantage. The custom of employing vaginal irrigation in normal labors has been shown to be bad.

Speaking of the internal use of water, the author passed by its diuretic and diaphoretic effects, and first considered the advantages of washing out the stomach in dyspepsia and indigestion. In recent cases a few washings with some care in diet often cure; but in chronic gastritis the treatment has to be continued for some time. The sipping of hot water at intervals before breakfast is of benefit in indigestion, but it should not be taken just before the meal. Of recent date also is the introduction of the treatment of gastric disturbance in infants by washing out the stomach. In summer diarrhœa no treatment is more beneficial

than irrigation of the large gut. It is also of value in catarrhal jaundice.

Cold water to the surface of the body acts chiefly through mechanical and thermal influence, and has a wide field of usefulness. The reaction which follows the application of cold water to the surface has a remedial effect in many affections, among which are certain neurasthenias in robust patients; it takes the place frequently of so-called tonic medicines. Dr. Baruch reviewed the use of cold or tepid water in the reduction of the temperature of the body in fevers, and the mortality statistics of typhoid fever, according as the disease had been treated by the usual method or by the employment of the bath. The usual mortality, he said, has been from 21 to 26 per cent., or higher, whereas Brandt and others show a mortality rate under the treatment by water of only 7 per cent. or less. He concluded his paper by strongly recommending Brandt's method of treating typhoid fever. The bath employed by him has been of a temperature of 65° F., but he suggested that it it may be better to employ a higher temperature, gradually lowering it by adding colder water, which, of course, would necessitate leaving the patient in the water a longer time.

Dr. J. Harvie Dew read a paper on the same subject, viewing it rather from the standpoint of physiology. At the beginning, he said, it is necessary to recognize the following facts: 1. The chief component part of human bodies in fair condition is water. Its relative proportion to all the solid constituents has been estimated at from two-thirds to three-fourths the entire weight. 2. Water constitutes almost the total volume of each of the circulatory fluids, including those of digestion. 3. It is the essential medium by which digestion is accomplished, absorption is made possible, and the transportation of the elements of nutrition to the various tissues of the body is made easy. 4. As water enters so largely into the composition of the tissues, it becomes of corresponding importance to every process of assimilation. 5. Water is not only the medium of transportation of nutritive elements introduced by absorption, but it is also the medium by which all waste matters are held in solution and are conducted to their several points of exit. 6. Observation and experiment have shown that from three to four pints of liquid food are required to maintain the normal functions and weight of an individual weighing from 140 to 150 pounds. 7. It is a clinical fact that wherever we find persons thin in flesh it can be noted that by habit or for other reasons they are taking very small quantities of liquid food; while, on the other hand, all well preserved or fleshy persons will be found to be copious drinkers of fluids in one form or another. 8. It is also a clinical fact that in every morbid or diseased condition of the system, whether organic or functional, primary or secondary, the functions of digestion, absorption, assimilation, secretion, and excretion, embracing elimination, become in one way or another disturbed—sometimes one or more of these functions, at other times all of them to a more or less degree in the same patient. 9. It is not only important to note these disturbances as they are exhibited in well defined diseases, but it is equally important to recognize the fact that a very large proportion of the diseases and troubles to which the human body is liable have their origin primarily and absolutely in some improper performance of these functions.

From these facts one would recognize at once the necessity for a plentiful supply and use of fluids, both in the maintenance of health and in the restoration thereto from disease.

The discussion of these two papers was made the special order of the next meeting.

Foreign Correspondence.

LETTER FROM AUSTRALIA.

The Theories and Treatment of Snake-Bite in the Australian Colonies.

In an interview with Dr. Creed, of Sydney, I gained the following opinions on the treatment of snake-bite. Dr. Creed said:

From the experience which I have had of cases of snake-bite in New South Wales, and from inquiries I have made as to the particulars of others which have occurred in the practice of my friends who have kindly given me an account of them, I have been obliged to arrive at the conclusion that, with the exception of the species of *Hoplocephalus*, especially the "large-scaled snake," or, as it is called in Tasmania, the Diamond snake (*Hoplocephalus superbus*), and the brown banded or tiger snake (*Hoplocephalus curtus*), the death adder (*Acanthophisantaretica*), the brown snake (*Diemenia superciliosa*), and a large and

vigorous specimen of the black snake (*Pseudechis porphyriacus*), the danger of death from the effects of the bite of the numerous venomous snakes common to the colony is very much exaggerated, and that in the majority of cases showing serious symptoms, these symptoms are really the effect of intense fear and not of snake poison.

The doctor says that the essential object to be attained in the treatment of every bite from a venomous snake is the prevention of the absorption of the poison, and this can be done only by the stopping of the circulation as quickly as possible between the bite and the heart, and the prompt and efficient excision of the punctured part to such a depth as shall insure either the absolute removal of the injected poison, or at all events, its exposure to such an extent that it can easily be removed by washing with the nearest attainable fluid, preferably water. He strongly insists on the advantages of the excision of, instead of incision into and about, the puncture caused by the teeth of venomous snakes, for the following reasons: As the longest poison-fang of the largest Australian snake is less than one-fourth of an inch in length, excision of the very lowest point of the puncture is easily practicable by any intelligent person, without danger of causing more serious hemorrhage than can easily be controlled by the application of a pad. If done in this way the whole of the poison will be removed. On the other hand, incision made into and about the wound may or may not remove the venom, which might easily be retained at the original spot into which it was injected by the bite, if the cut made did not actually enter into and freely expose it. In addition, the danger from hemorrhage would be very much greater from the wound made by the incision, as the point of the knife would probably enter to a greater depth than the wound made in excision. In fact, unless the operator has a fair knowledge of anatomy, he might easily in many places wound an artery lying comparatively superficially, and cause death by hemorrhage in a few minutes.

With regard to sucking the wound, the entire removal of the poison by its means is problematical, and such treatment is not without danger to the person sucking. Unless made by a person with some knowledge of anatomy, he thinks the excision should be made by pinching up the parts to be cut away, and then removing them with the middle of the blade, and not by inserting the point of the knife and cutting round the bite. The wound should be well washed and moderate bleeding encouraged. It would be well to wash it with a weak solution of permanganate of potash, or it might have an application of strong nitric or carbolic acid, or the actual cautery. The permanganate is probably an antidote if brought in direct contact with the poison, but when thrown into the general circulation it can be only of little if any use, for it will attack not only the snake poison but will oxidize all organic matter with which it comes in contact. After the ligature is removed the patient should be carefully watched and symptoms treated, the best stimulant being ether under the skin. Compulsory exertion or walking the patient about is forbidden. This notion of keeping the patient awake is carried even to a ludicrous extent. In a case in New South Wales the local brass band was hired to play their most fierce tunes to keep the patient from sleeping; the patient made a recovery from the bite as well as from the infliction of the music. Dr. Creed uses alcohol for the treatment of the symptoms of exhaustion but not as a special treatment of the poison.

By experiments made by Mr. Krefft, in Sydney, it has been demonstrated that no effect follows the infliction of a bite by one of the most venomous snakes either on itself or on another venomous snake of the same or a somewhat similar class. From this Dr. Creed argues that if a physiological antidote is to be discovered, it must be sought in this peculiar property inherent in the snake, which can hardly be merely consequent on structure, but may be the result of some substance diffused in the snake itself, which diligent research may demonstrate to be capable of isolation, and, if so, of use in the treatment of snake-bite. Dr. Creed is of the opinion that in order to prevent fear from acting harmfully on the patient he would when needed use ether as an anæsthetic. He would keep the patient barely unconscious for an hour or two, then allow him to recover enough to judge of his condition, watching pulse and respiration all the time carefully. If necessary he would bring the patient again and again under the influence of the ether, so long as might be required.

He feels there is a germ of useful treatment in this suggestion. I am told that the treatment of snake-bite by ether has been tried by Dr. Bancroft, of Brisbane, with most encouraging results. Dr. Creed feels that there has not been up to the present time a physiological antidote found for this terrible poison of snakes. This is not the opinion

of other members of the profession, and I now ask your attention to views held by a prominent physician of Victoria.

An interesting article on snake-bite and its treatment was read recently by Dr. Augustus Mueller before the Victorian Medical Society. The doctor stated that his experience and observations have made him acquainted with the poison of the black, the brown, and the tiger snakes only, and he did not extend his views to the poison of any other varieties of Australian snakes, nor for those of America and India. Inferences might be drawn that the antidote he suggested would be useful in all; but inferences were not proofs.

To be brief, I will state that the doctor's theory is that the poison of the snake does not act as a special blood poison; all the symptoms are due to deficient nerve action. The insidious venom travels quickly to the nerve centers, affecting in rapid succession the anterior columns of the cord, the vaso-motor centers of the brain, and causing paresis and paralysis of the muscles of the lower extremities, accompanied by rapidly diminished force of heart action and blood pressure, and in a very short time by sleep, which in severe cases deepens into coma; the latter sometimes remains till death, but more frequently passes off again, even in fatal cases. The usual method of death is by syncope. Dr. Mueller then made some interesting comparisons between the effects of the poison of the Australian and the Indian snakes. Both are without doubt nerve poisons. The Australian snake-poison seems more diffusible and develops its effects more quickly, and is distributed uniformly over the whole motor system. It is on this account, and also on account of the smaller quantity of poison at the disposal of Australian snakes that their bite is less frequently fatal than those of the Indian snakes of the East Indies.

The poison of the latter snakes, especially of the cobra, seems less diffusible, and takes a longer time as a rule to develop its effects; but once fully developed the course is much more quickly fatal, owing to the fact that the poison concentrates its action on special nerve centers, instead of being equally distributed over all. Dr. Mueller has had thirty years' practice in a district in which snakes abound, and he has unusual opportunities of studying the effects of snake-bite, both on men and the lower animals. He tells how he came to have his attention called to the use of the antidote that he now so strongly recommends, viz., strychnia. Strange to say it was in a case of spider-bite in a child two years old. He asserts that effect of spider-bite differs only in degree from that of snake-bite. Incidentally it may be mentioned here that there are a number of fatal cases of spider-bite on record in the Colonies; in Queensland they are not at all of very rare occurrence. In commenting on this case the doctor says he was at once struck by the close resemblance, if not identity, of symptoms here present with those of snake-bite—loss of power in the legs, extreme pallor, coldness of skin, feeble heart action, with pulse scarcely perceptible at the wrist, dilated pupils insensible to light, and inability to move either arms or legs.

Treatment was begun with the usual orthodox remedies—eliminative, stimulating, alkaline, etc., etc., but all failed. The collapse increased rapidly, respiration became difficult, eyes glassy, heart's action barely perceptible, pulse gone at the wrist. In short, the patient would die in a few moments to all appearances. Now came to me a happy thought, says the doctor; like a flash it passed through my mind that the child's inability to walk soon after being bitten might have been caused by the subtle poison exerting a specific depressing effect on the motor cells in the anterior columns, gradually extending over the rest of the motor and also the vaso-motor centers. All the ominous symptoms thus found a ready explanation, and strychnia suggested itself as the remedy for this condition of things. To use his own words, "I hastily procured some strychnia, and injected ten minims of the official solution into the arm. In a half hour's time my little patient was sitting up, snatched, I have reason to believe, from the very jaws of death." He then relates a case in which he used this remedy in a venomous snake-bite, with equally good success. In another case he produced, through the agency of the strychnia, a marvellous change in a desperate case in less than an hour, watched the patient for a number of hours and then gave his sanction to his going home. The lad felt strong and entirely well, mounted his horse and rode off; but he died next morning before the doctor could reach him. "I did not know then, as I do now, that even strychnia is more quickly decomposed and thrown out of the system than the snake-bite poison and that the latter will lurk about in the holes and corners of the system and resume its work of destruction as soon as the antagonist is removed that kept it in check. I had injected into

the system of a mere boy, within half an hour not less than one-third of a grain of strychnia; but even this comparatively large quantity was evidently only just enough to counteract for a time, and as long as it lasted, the deadly venom. If I had only dared to push the use of the drug a little further, until it produced the usual symptoms in a moderate degree; if I had only directed it to be taken internally, from time to time in ordinary doses as I do now, after the painful lesson this case gave me, I have not the remotest doubt, from what I have seen of its action since, that the life of this lad would have been saved."

Notwithstanding the fatal termination of this case, however, his faith in the antidote was confirmed rather than shaken, for he felt convinced that its failure was wholly and solely due to the mistake he made in not continuing in it small doses, until it produced slight muscular spasms. Though the lad had received within a half hour four times the quantity we are allowed to give in ordinary practice in one dose, it was evidently not sufficient to counteract completely and effectually the deadly venom with which his body was saturated, but only checked it for a time.

Dr. Mueller feels quite confident that snake-bite and strychnia react on each other in the human organism with the unerring certainty of two chemical tests. The dose of the antidote must be in proportion to the severity of the symptoms, but even a little more than is required can do no harm, for its effects pass away very quickly in snake-bite. A few muscular twitches, a little stiffness about the neck or about the mouth, are nothing compared with the horrid sensations which the deadly snake-poison produces.

Dr. Mueller then produced some collateral evidence in regard to this treatment. In China and India where the terrible raja commits its destruction of human life each year, a famous antidote with the natives is a pill which is called in China Nooang. On examination this is proved to belong to the strychnos family; that is, the pill is made from a plant of this family. Another famous antidote is the nuts of the Simaba Cedron, among the natives of Central and South America. Its active principle resembles strychnine; it probably resembles more closely quassine, yet this leads us to the point that it is among the bitter tonic alkaloids that we are to look for the antidote for snake-poison. The doctor concludes with his opinion of alcohol: "Stimulants are, no doubt, of use in stimulating the heart; but their action is transitory, because they do not attack the enemy in his stronghold; they do not permanently raise and alter, as the strychnine does, the depressed and partly suspended function of the motor centres, which lies at the root of all the mischief, and is, beyond doubt, the cause of death in snake-bite."

C. C. VANDERBECK.

PERISCOPE.

Hereditary Syphilis.

The Vienna correspondent of the *British Med. Journal*, Jan. 12, 1889, states that at a recent meeting of the Imperial Royal Society of Physicians of Vienna, Professor Neumann read a paper on hereditary syphilis. The questions with which the lecturer dealt were the following:—1. What is the condition of the offspring when the father and mother were healthy at the time of conception, and the mother became infected at a later date (pure post-conceptional syphilis)? 2. What is the effect of post-conceptional syphilis with reference to the offspring when the father was already syphilitic at the time of procreation? 3. What is the effect of post-conceptional syphilis with reference to the offspring when the condition of the father's health at the time of procreation is unknown, and the mother was healthy at the time of conception, and became infected at a later date? 4. What is the condition of the offspring when the infection and the conception took place at the same time? And, 5, when the infection of the parents occurred before conception?

Professor Neumann's paper was based on cases most of which he had observed during eight years in his clinic. Of these only 102 were available for the purpose he had in view, as accurate data concerning the offspring could not be obtained in the rest. The physicians of the three obstetric clinics of the General Hospital and those of the Vienna Foundling Hospital also took an active part in the investigation. With regard to pure post-conceptional syphilis, Professor Neumann had observed 11 cases; of these 5 patients were healthy, and the rest, in part, presented the appearances of syphilis, and, in part, miscarriage occurred. As regards post-conceptional syphilis, where the father was syphilitic, 5 children were found to be healthy, 2 children were affected with syphilis, and in 5 cases miscarriage had occurred. In the cases of post-con-

ceptional syphilis, where the father was unknown, there were 10 healthy, 1 syphilitic, and 7 dead children; 2 children were still under treatment. In the cases in which conception and infection took place at the same time, 15 children were healthy, 1 died of peritonitis, 4 were syphilitic; the fate of these cases could not be ascertained, and in 21 instances still-birth occurred. Among 25 cases of syphilitic infection before conception, there were 10 healthy children, 8 cases of miscarriage, and 4 of maceration; 3 were still under treatment.

Professor Neumann arrived at the following conclusions: 1. A syphilitic mother may convey the disease to her offspring at any stage of her affection, whether the infection has taken place before or after the conception. 2. A mother who has contracted the disease after conception sometimes transmits it to the fœtus. In the case of pure post-conceptional syphilis the transmission of the affection to the child is extremely rare, especially when the mother has become infected in the last months of pregnancy. 3. When the infection of the mother has taken place after conception, and the father was syphilitic at the time of procreation, the effect on the offspring is greatly intensified; the children in these cases die *in utero*, or are born with signs of syphilis. 4. In the case of post-conceptional syphilis, where the infector is unknown, the proportion is the same as in pure post-conceptional syphilis; syphilis acquired in the last months of pregnancy is usually transmitted to the offspring. 5. When infection and conception occur at the same time, the children die in one half of the cases. It is nevertheless remarkable that a great part of the offspring remain free of syphilis, in spite of the fact that the disease was in an active state in both the parents at the time of conception. This disproves the assertion that a healthy child can never be born when both parents are syphilitic at the time of conception. On the other hand, the assertion that healthy children are born only when the syphilis of the parents is seven years old, is also negatived. 6. In the case of infection before conception, the period at which conception occurred has to be taken into account; the longer the interval between infection and conception, the more favorable is the prognosis for the offspring. 7. The offspring has the best chance when the mother only contracts syphilis in the last months of pregnancy, while the father was healthy at the time of procreation; the same is also true of the offspring of parents suffering from tertiary syphilis. The offspring has the least chance when infection and conception have occurred simultaneously, or when the father was suffering from recent syphilis at the time of procreation. 8. This last observation also elucidates the question as to paternal syphilis. It is especially the cases in which the father was syphilitic at the time of procreation, and the mother became infected only after conception, and the child was soon after the infection born in a macerated condition, which prove the extremely injurious nature of paternal syphilis. This is opposed to the observations of Boeck and Dewere, who state that the child of a syphilitic father is always healthy.

These data, concludes Professor Neumann, show the sad fate of the children of syphilitic parents, as, out of 109 cases, only 44 were born healthy; and, according to inquiries made by Dr. Friedinger, director of the Vienna Foundling Hospital, only the minority of them live. Hereditary syphilis must, therefore, be considered one of the most terrible plagues of infant life.

Two Cases of Thyrotomy for the Removal of Malignant Disease of the Larynx.

At the meeting of the Clinical Society of London, Jan. 11, 1889, Mr. Butlin read notes of these cases. In pursuance of an opinion expressed by him in a previous paper, that it is not necessary to remove the cartilaginous or bony framework of the larynx in certain cases of intrinsic carcinoma of the larynx which are suitable for operation, two cases were reported. The first was a case of squamous-celled carcinoma (epithelioma) of the larynx in a woman 27 years old. The thyroid cartilage was divided in November, 1887, and the disease was cut and scraped out. She made a good recovery, and was well a year later, and free from every sign of cancer. The second was a case of the same disease in a man 51 years old. A similar operation was performed in 1888. The man recovered without hindrance, and was well in September. The author pointedly drew attention to the comparatively trivial nature of the operation in cases of malignant disease of the larynx of limited extent. In another instance in which he performed an exploratory thyrotomy in a man advanced in years, and found the disease too extensive for removal, he closed the wound, and the man recovered and left the hospital wearing a tracheotomy tube.—*British Med. Journal*, Jan. 19, 1889.

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THE DANGER OF CALOMEL INJECTIONS.

The recent studies in connection with the use of calomel injections in the treatment of syphilis have led to a revival of interest in this subject on this side of the Atlantic. But there are two reasons why those who are not yet committed to it may hesitate about adopting this method. One of them depends upon the fact that so eminent a syphilographer as Neumann, of Vienna, has recently pronounced against the general utility of calomel injections, and the other is that these injections may be dangerous to health or life.

Attention has recently been directed to this point by an article by Prof. J. W. Runeberg, of Helsingfors, in the *Deutsche med. Wochenschrift*, January 3, 1889, who refers to a few cases of mercurial poisoning caused by the medicinal administration of salts of this metal, and describes in full a case coming under his notice in which death was attributed, with much show of reason, to the absorption of mercury from points at which calomel had been injected.

The form of disease caused by accidental and chronic mercurial poisoning is usually that of an acute dysentery, and this was seen in Runeberg's case, while the autopsy disclosed the presence of a cavity containing unhealthy pus and a considerable quantity of mercury.

The case referred to indicates that one of the chief merits of the hypodermic use of calomel has associated with it a feature of danger. It is an advantage to have a method by which mercury can be administered by the physician with the expectation that it will be gradually absorbed; but the disadvantage is that the rate of absorption is not determinable, and some injections may be carried into the system promptly, while others may be taken up slowly and produce, with later ones, a culminating effect. And if such an effect makes its appearance, it is no longer possible to limit it by discontinuing the administration of the medicament. The quantity already in the body cannot be withdrawn, and it may continue poisoning the system long after it was first deposited.

These dangers deserve consideration, although in practice they have not proved to be very imminent. The cases of mercurial poisoning caused by calomel injections are very few and most of them have occurred in persons in an anæmic condition, predisposed to general disturbances. Still in one case, reported by Kraus, the patient was in good condition, and it must be remembered that syphilitics are not rarely in this very state and that always when they are so, and generally when they are not, some other way of administering mercury may well be chosen for them.

TETANUS NEONATORUM.

There was a time when tetanus of the new-born was so frequent that it was more or less an object of fear to physicians and parents. But in these days it has become so rare that it is hardly ever taken into consideration in estimating the perils of the first period of life. When it occurred, in former times, it was generally attributed to traumatism, and charged to improper management of the stump of the divided umbilical cord. Nowadays the germ theory of disease has come in to suggest a totally different conception of the nature and mode of origin of tetanus, and on the one hand we are asked to make our views in regard to it conform to the possibilities of infection with the germ found in earth by Nicolaier, and on the other hand we are confronted with the claims of Verneuil that tetanus is of equine origin and can always be traced to some direct or indirect infection from horses.

The arguments in support of both of these theories have much that is plausible about them, but nothing which to a keenly critical mind can be said to be conclusive. Both earth and horses are widely enough distributed to make it possible to invoke either of them to explain what takes place in almost any land; and certain experiments have been performed which indicate that tetanus may be produced in some of the lower animals with matters derived from the soil or found where horses are kept. But, none the less, the subject is still involved in much obscurity, and cases of tetanus in human beings occur which are as inexplicable to-day as were those which were observed many years ago.

An illustration of this fact is found in a recent study of trismus neonatorum, as it is seen in Iceland and in the Faroe Islands and the Hebrides, by Dr. H. Labonne, the results of which are published in the *Gazette Hebdomadaire*, January 11, 1889. Dr. Labonne makes the mortality from tetanus neonatorum in these islands range from thirty to sixty-seven per cent. In studying the causes of this frightful mortality he finds nothing to support the theory that the tetanus neonatorum found here is due to infection with a microbe, although he hazards a guess that the birds which furnish so much of the food of the natives, and so much of their bedding, may also supply them with some bacterium of tetanus. On the other hand, certain practical experiments which he cites indicate that the almost exclusive use of the flesh and oil of birds as food by nursing women brings about states of the milk which directly or indirectly induce tetanus in their nurslings.

The report of the investigations of Dr. Labonne is interesting, although it is not conclusive. It would be more valuable if it gave an account of the management of labor in the lands he visited, and the entire care of infants during the first days of their life. Both of these matters are of great importance in estimating the probable cause of any disease like trismus neonatorum; and without a knowledge in regard to them it would be impossible to form a rational theory of the etiology of the disease.

TREATMENT OF PUERPERAL SEPSIS.

Grave septic intoxication during the lying-in period is one of the most formidable conditions which confront the medical man, and one which sometimes puts his resources to the sharpest proof. For this reason it is desirable to give the widest circulation to any method for the treatment of puerperal sepsis which seems, on its face, to be rational and to have stood the test of experience in a sufficient number of cases.

Such a method has been in use for some time by Prof. Max Runge, of Göttingen, and is described in full in the *Deutsche med. Wochenschrift*, Jan. 3, 1889. In brief, the method consists in the employment of the customary local treatment, with the addition of lukewarm baths and the administration

of large doses of alcoholic liquors and full nourishment. Runge calls attention to the improvement in the prospects of women with puerperal sepsis which came with the introduction of an intelligent method of local treatment, and the comparative powerlessness of general medication. Of all the medicaments used in this condition, he thinks alcohol to be the only one of real value. Antipyretics he unqualifiedly condemns, as generally useless and often dangerous. This for two reasons: One, that the fever in puerperal sepsis is not usually of a high grade, and that mere elevation of temperature is a symptom which does not demand active interference; and, two, that antipyretics almost invariably ruin both appetite and digestion.

On the other hand, he finds that the administration of large quantities of wine and brandy, and the use of one or more lukewarm baths (22° — 24° Reaumur, or 82° — 86° Fahr.), improved the appetite of his patients so that it was not difficult to get them to take large quantities of nutritious and satisfying food.

The quantity of alcohol which may be given to a patient with puerperal sepsis may be gathered from the fact that one of Runge's patients took within a week over ten bottles of port and Madeira and about two quarts of Cognac. It is noticeable that even such large quantities of alcohol do not produce symptoms of intoxication, and that intolerance of large quantities is usually a sign of beginning convalescence.

As to the baths, Runge used them—not to reduce temperature, but to improve the general condition of his patients and to increase their disposition to take food. The idea of placing a lying-in woman in a full bath may seem startling to others; but Runge has never seen it do any harm, and has always seen it do good. The operation to be successful must be conducted by a skilled nurse or a physician, the temperature of the water and of the room must be right. The bath may last from three to eight minutes, and it is to be used according to the indications. The most that Runge ever administered was four in a day; usually he found one or two sufficient. The highest number he used in any one case was nineteen, in the majority of his cases from five to seven baths were sufficient, and in some of his cases only two or three were used.

The treatment outlined above is presented to his professional brethren by Prof. Runge in a manner which cannot fail to impress any one who reads his paper. In it there is no attempt to overrate the value of the method, and the whole argument bears the impress of careful thought, close observation and wise deduction. In theory his method commends itself to one's judgment, and in practice he has found it successful. We believe our readers will find it to their interest and helpful to their patients if they will give the method a trial, remembering that it can be expected to succeed only when combined with judicious local measures.

REGULATING THE SALE OF MILK.

We call attention to the suggestions—which are published in this number of the REPORTER—made by a Committee of the Board of Health of Philadelphia in regard to a law to regulate the sale of milk in this city. The fact that more than two hundred and fifty thousand quarts of milk are used in Philadelphia every day indicates the importance of some such legal regulation of its sale as is here proposed. Our only comment on the plan of the Committee is that it might well be incorporated in and assimilated with a more general law, securing a systematic inspection of all articles of food and drink. If such a measure could be adopted soon, it would be better than a law for only one article. But if the former is not attainable at present, we hope a carefully prepared law in regard to regulating the sale of milk may speedily be passed.

AN ABRUPT ENDING.—We have information from a trustworthy source that the official connection of Dr. John B. Hamilton with the *Journal of the American Medical Association* terminates this day, February 9. This sudden relinquishment of an office which he entered upon so recently will be a cause of surprise to those who have followed his vigorous editorial policy for the past six weeks. The reason for the step has not reached us when this note is written, but it may be public by the time it is printed.

THE MIDDLETON GOLDSMITH LECTURE for 1889 will be delivered by Dr. Reginald H. Fitz, Shattuck Professor of Pathology in the Harvard Medical School, in the hall of the New York Academy of Medicine, on Saturday, February 16, at 8½ o'clock P. M. The subject will be: "Acute Pancreatitis, with an especial consideration of Pancreatic Hemorrhage, Hemorrhagic Pancreatitis, and Subperitoneal Fat Necrosis."

BRITISH STUPIDITY.—The *British Medical Journal*, Jan. 12, contains a letter from a correspondent in Paris, in which the prizes awarded by the French Academy of Sciences are mentioned. In this letter the following statement occurs: "The Prix Cuvier in Geology was awarded to Mr. Joseph Leidy, of Harvard University." This statement is no reflection upon the fame of Dr. Leidy, but is rather an illustration of editorial ignorance or carelessness.

THE DOCTOR'S BADGE.—The *Medicinische Monatsschrift*, January, 1889, turns its attention to the question of a distinguishing mark for physicians, which has been seriously discussed during the past year by some of the medical journals. It quotes the *Medical World* as asking those who have courage enough to make themselves heard on this subject, and adds: "We accept this invitation, but would prefer to substitute for the olive green coat proposed by the *World*, a gray one. Instead of the letters M. D. on the collar, we would regard as more practical large ear trumpets of the same material, as a distinguishing mark of the bearer which would be visible from a great distance, and because they would serve as collectors of sound vibrations and facilitate the approach of the call of suffering fellow men to the membrana tympani of the wearer."

ELECTION AT THE UNIVERSITY OF PENNSYLVANIA.—At their meeting on Tuesday, February 5, Dr. J. William White was elected Clinical Professor of Surgery, and Dr. John Guitéras was elected Professor of Pathology and Morbid Anatomy.

Dr. John Guitéras is a native of Cuba, where he received his preliminary education, graduating from the Medical School of the University in 1873. In 1879 he was appointed by the President of the United States a member of the Havana Yellow Fever Commission, and took charge of the investigations in morbid anatomy. In 1880 he was appointed in the Marine Hospital Service, serving in St. Louis, New Orleans, Key West and Charleston. He was ordered by the Government to investigate epidemics of yellow fever in Vera Cruz, 1883; Key West, 1887; Florida, 1888. Dr. Guitéras has lectured in various medical colleges, and has made valuable contributions to medical science. In order to accept the Chair of Pathology he will resign his commission as Passed Assistant Surgeon U. S. Marine Hospital Service.

Dr. J. Wm. White, the new Professor of Clinical Surgery, is a Philadelphian, and was graduated at the University in 1871. Since then he has been surgeon to several hospitals in Philadelphia.

Besides these changes, a Clinical Chair of Orthopædic Surgery in the University Hospital was created, and a Chair of Histology and Embryology in the Medical Department. The former position will be occupied by Dr. De Forest Willard, and the latter by Dr. George A. Piersol.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

A COMPEND OF THE DISEASES OF THE EYE; INCLUDING REFRACTION AND SURGICAL OPERATIONS. By L. WEBSTER FOX, M.D., Ophthalmic Surgeon to the Germantown Hospital, etc., and GEO. M. GOULD, M.D. Second edition revised and enlarged, with 71 Illustrations. Philadelphia: P. Blakiston, Son & Co., 1888. Small 8vo, pp. 164. Price $1.00.

That this little book has grown in usefulness there can be no doubt. Nearly all of the chapters have undergone revision, and many have gained by rearrangement. Treatment has been brought to date, and puzzling technicalities have been carefully replaced by either proper terms in full or by common expressive equivalents. Of the newly added cuts, however, all but one are taken from Meyer, without any indication that they have been borrowed.

Taken as a whole, the book is a good and trustworthy guide for its intended readers—undergraduates and busy general practitioners—but to them it is only fair to say, in the authors' own words: "Cultivate a habit of close and accurate observation of the eye. The successful ophthalmologist often suspects or bases diagnoses upon a perception of subtle and delicate differences in the external appearance of an eye that he would have difficulty in explaining to another"—as this is the only way by which they may hope to arrive at correct diagnosis, proper prognosis, and judicious treatment in cases of ophthalmic disease.

ELEMENTS OF PRACTICAL MEDICINE. By ALFRED H. CARTER, M.D., Lond., Physician to the Queen's Hospital, Benningham, etc. Fifth edition. Small 8vo, pp. xvi, 472. London: H. K. Lewis, 1888.

The purpose of this book is stated by the author to be: to provide students with a simple introduction to the study of systematic medicine, and to bring the essentials of the subject clearly and tersely within the grasp of those unable to master larger treatises. It is high praise to say that Dr. Carter has attained his object. His book is both terse and clear; and its terseness is not secured by sacrificing anything essential to such a work. His descriptions of diseases and morbid states are simple and yet full enough to be very useful, and his recommendations in regard to treatment are judicious and easy to remember. He avoids excess of detail in the former, and in the latter he lays down general principles and has not burdened his book with prescriptions.

As a whole his work is excellent, and would prove of value to students if its reading were made to accompany their attendance on didactic and clinical lectures. Equally is it calculated to be a help to busy practitioners—especially those who have not the time or inclination to consult elaborate treatises.

—Messrs. J. B. Lippincott Company announce to the profession the publication of a Cyclopædia of the Diseases of Children, medical and surgical, by American, British, and Canadian authors, edited by John M. Keating, M.D, in four imperial octavo volumes; to be sold by subscription only. The first volume will be issued early in April, and the subsequent volumes at short intervals. This is the only work of the kind that has been published in English.

PAMPHLET NOTICES.

[Any reader of the REPORTER who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request stating where the notice was seen and *enclosing a postage-stamp.*]

206. SOME ACCOUNT OF THE MEDICAL PROFESSION IN NEW HAVEN. By FRANCIS BACON, M.D., New Haven, Conn. 44 pages.

207. TWO SUCCESSFUL CASES OF BRAIN SURGERY. By CHARLES B. NANCREDE, M.D., Philadelphia. From the *Medical News*, November 24, 1888. 14 pages

208. IS THE ELECTRIC LIGHT INJURIOUS TO THE EYES? By GEORGE M. GOULD, M.D., Philadelphia. From the *Medical News*, Dec. 8, 1888. 23 pages.

209. EXPLORATORY TREPHINING AND PUNCTURE OF THE BRAIN ALMOST TO THE LATERAL VENTRICLE. By W. W. KEEN, M.D., Philadelphia. From the *Medical News*, Dec. 1, 1888.

210. PRELIMINARY REPORT OF AN OPERATION FOR THE FORMATION OF AN ARTIFICIAL PUPIL THROUGH THE SCLEROTIC COAT OF THE EYEBALL. By GEORGE STRAWBRIDGE, M.D., Philadelphia. From the *Medical News*, Dec. 15, 1888. 12 pages.

211. CONDITIONS RENDERING DIAGNOSIS DIFFICULT IN PELVIC AND ABDOMINAL DISEASES. By T. B. HARVEY, M.D., Indianapolis, Ind. 14 pages.

212. EL PASO, TEXAS, AS A WINTER HEALTH RESORT. By W. M. YANDELL, M.D., El Paso, Texas. 10 pages.

206. The history of the medical profession in any part of the United States, if well written, could not fail to be of interest; but that of the older sections of the country has a peculiar charm, because it takes the student back to the time in which our forefathers were laying the foundation for the superstructure which in our day extends so far and towers so high. In the pamphlet before us Dr. Bacon has brought together, in most attractive and entertaining shape, reminiscences of the early practice of medicine in and near New Haven, which have a much more than local interest. The work is done with a grace of style and a shrewdness of commentary which are characteristic of the family to which the author belongs.

207. In one of the cases which Dr. Nancrede reports he trephined the skull to find a bullet, the course of which he traced to the base of the skull but could not follow further; in the other he excised the thumb-centre for Jacksonian epilepsy. Both patients recovered. The description of these operations is both interesting and instructive, and the paper which contains it is a valuable contribution to the literature of surgery of the brain.

208. Dr. Gould, after a careful review of the evidence in regard to the effect of the electric light upon the eyes, answers the question of the title of his paper in the negative. More than this, he shows that the cases in which the electric light has proved injurious to the eyes are to be attributed to its improper use, and he urges the general adoption of electric lighting for all public halls. His pamphlet contains a valuable bibliography of the subject.

209. The literature of brain surgery bids fair soon to rival that of abdominal surgery; and Dr. Keen's contributions to it are always of great interest and

value. In the pamphlet before us he describes, with excellent illustrations, the history of a case of abnormal intracranial pressure, in which he trephined the skull, and punctured the brain, in the hope of giving vent to the fluid which caused the trouble. Unfortunately he failed to reach the fluid, although he came very near to it. His patient died, and the autopsy showed that Dr. Keen's exploratory puncture had come within a quarter of an inch of the fluid, which was contained in a distended left ventricle.

The experience of this case, added to the operator's general experience, leads him to propose tapping the ventricles of the brain as a definite surgical operation, and he describes the method by which he thinks this operation may be most safely performed. Such a proposal challenges the thoughtful attention of all surgeons and students of injuries and diseases of the brain, and Dr. Keen's pamphlet cannot fail to attract very wide spread notice.

210. Dr. Strawbridge makes an exceedingly ingenious suggestion for the treatment of incurable leucoma, and one which is likely to attract as much attention as Von Hippel's method of trephining the cornea. At the time of publishing his article he had made a number of successful experiments by his method upon the eyes of rabbits, and he had done two operations upon human eyes. Sufficient time had not elapsed in the latter cases to demonstrate what the ultimate result of the operations would be; and this result will be looked for with the deepest interest.

211. Dr. Harvey calls attention to the necessity for examining patients carefully in order to avoid the error of overlooking unconspicuous, but important disorders. The special field which he considers is that of the abdominal and pelvic viscera of women; but what he says has a still wider range of applicability.

212. Dr. Yandell has taken up the teaching of Dr. Denison, of Denver, and applied it to the case of El Paso, in such a way as to indicate that the latter is a very desirable place for the residence of persons affected or threatened with consumption. He claims that El Paso has, in common with southern New Mexico and southern Arizona the best Winter climate in the United States for consumptives and asthmatics, as well as persons suffering with other chronic pulmonary affections.

LITERARY NOTES.

—The *Independent Practitioner*, a dental journal published in New York and Philadelphia, has changed its title to *The International Dental Journal.*

—The *Journal of the Respiratory Organs* is the name of a new magazine, edited by J. Mount Bleyer, M.D., and published by Napoléon Thompson, of New York. The first number is dated January, 1889, and contains 13 octavo pages of reading matter. It is to be issued on the fifteenth of each month; subscription price $1.00 a year.

—The American Biographical Publishing Co., Philadelphia, announces that a work on American Resorts, with notes upon their climate, by Bushrod W. James, A.M., M.D., with a translation from the German by Mr. S. Kauffman of those chapters of "Die Klimate der Erde," written by Dr. A. Woeikof, of St. Petersburg, Russia, that relate to North and South America and the islands and oceans contiguous thereto, is in press and will shortly appear.

CORRESPONDENCE.

A Defense of Homœopathy.

TO THE EDITOR:

Sir: A few days ago, I was shown an editorial in the REPORTER, Oct. 6, 1888, entitled "The Homœopathic State Medical Society of Pennsylvania." I am sorry it had not come to my notice earlier, as I should have had a reply in your hands long ere this.

Your reference to the fact that the Homœopathic State Medical Society of Pennsylvania had just concluded an interesting meeting in Philadelphia, and had displayed a fitness for the discussion of important medical questions which would hardly be expected by those who are not familiar with the advances made of late by those who bear this designation," is perfectly correct; but you err when you say that "the proceedings at this meeting were so like those of any 'regular' medical society that it is hard to discover any homœopathy in them at all."

You err, however, when you state that "the tenets of Hahnemann have come to occupy but a minor and subordinate position in their (*i. e.* the Homœopaths') thoughts and practice." I doubt if there was one in all the large gathering of members of our school at the session of the society who subordinated the Homœopathic principle in his thoughts or practice. Never have the laws of Hahnemann been so well understood, or so freed from the things that unfortunately since his day have somewhat hampered the growth and development of his system. The law of *similia similibus curantur* is upheld by our school no less vigorously to-day than formerly. But time and the progress of things have taught us wherein we were weak and needful of strength. The transactions of our societies are therefore more liberal. We are striving to give the principle of the *similars* its proper value, and to that end we investigate and court investigation. If our law of cure is universal in its application, our effort is to prove it; if it is not, still we aim to seek the truth and in the finding give it proper place. The old school is in need of an intelligent understanding of what we are really doing and of what we are really accomplishing. The time will surely come when the old school will believe as fully as we do, that the Homœopathic law is at least one of the laws of cure.

Is there not some mistake in the following

taken from your article: "The time will "yet come when . . . such men as made "the last meeting of the Pennsylvania State "Homœopathic Medical Society almost "undistinguishable from a similar meeting "of 'regular' physicians will not debar "themselves from association with all other "scientific medical men by holding fast to "a name which misrepresents them, and dis-"credits them in the opinion of men who "have no desire to be unjust or uncharita-"ble"?

Can you in all earnestness believe that such a time is near or ever likely to come? Is there a place in the old school of this city for the physician who has the courage of his convictions that Hahnemann demonstrated a principle in the laws of the similars? It is essential to the believers in Homœopathy that they class themselves together under the name which Hahnemann adopted; and this is true even for those who deny the *universality* of the Homœopathic law. What opportunity is afforded in the "regular" school for the study of the "similars"? Do you throw open to us your hospitals and your journals? Are we given fair-handed opportunity to demonstrate what we can do? When you allow us the freedom of action for which for years we have been pleading, then, and only then, can the two schools hope to commingle, and our title of "Homœopath" give place to that of plain "Doctor of Medicine."

I am glad that your article shows in some respects a spirit of fairness on your part. It is only by an unimpassioned, unprejudiced inquiry into the relative merits of the claims of the two rival schools that there can be entertained any hope of an ultimate solution of the problems of the hour.

Yours truly,

G. Maxwell Christine, M.D.

1043 N. Twelfth St., Philadelphia.

[This letter is given place in the Reporter because the writer has desired to have it published as a sort of justification of those who, he thinks, have been misrepresented in our columns. But, in doing so, attention is called to several points in it.

1. The writer cannot be aware of the belief and practice of many of his fellows in this city, or he would not venture the assertion that he doubts if there was one in the gathering spoken of who subordinated the homœopathic principle in his thoughts or practice.

2. He cannot be a careful reader of the journals of his own school if he believes that the law of similars is upheld as vigorously by his school to-day as formerly.

3. In reference to the appeal for a chance to work out homœopathic theories in regular hospitals: this is a most impracticable idea. There may be something more than coincidence in the fact that certain drugs produce in health symptoms similar to those of disease in which they may be administered with advantage; and this is a proper subject for unprejudiced investigation; but the claim that homœopathy, or any other "pathy" furnishes a universal law of treatment is condemned by all unbiassed scientific men. This condemnation is usually spoken of as if it applied only to homœopathy; but it applies equally to every exclusive dogma, whether it be homœopathy, or hydropathy, or electropathy, or vitapathy.

As asserted in our editorial, we believe the time will come when the rational men who bear the name of homœopath will drop this inappropriate and deceptive designation, and leave the title to those to whom it properly belongs—to the advantage of all concerned. It is not possible for assimilation to take place between such miscalled homœopaths, and those whose scientific methods they approve and imitate, until the former refuse to be called by a name which is practically false, and announce their adherence to those principles of reason which alone deserve the name of scientific. We know that this fact is appreciated by some who still permit themselves to be denominated homœopaths, and we hope that they will yet find occasion to declare publicly that what they believe of homœopathy is but a part of what experience teaches, and not what the real homœopath thinks it—an exclusive and universal law.]

Nasal Bougies.—A Correction.

To the Editor.

Sir: May I make a correction in the article on Nasal Bougies (Reporter, Feb. 2, p. 146), which you did me the honor to republish?

The strength of the nasal bougie is given as one-twentieth of a grain of atropine; it should be one-one hundred and twentieth of a grain of atropine.

Yours truly,

H. C. Wood, M.D.

Philadelphia, Feb. 4, 1889.

—Dr. Oliver Wendell Holmes has presented his medical library to the Boston Medical Library Association.

NOTES AND COMMENTS.

Regulation of the Sale of Milk in Philadelphia.

The Sanitary Committee of the Board of Health of Philadelphia at its meeting, January 29, 1889, presented a petition to be submitted to the State Legislature with reference to a regulation applying to the sale of milk in Philadelphia. The petition is rather voluminous, and states that the Board of Health, recognizing the necessity of a strict supervision over the milk supply of the city, whereby the purity of a most important article of food shall be secured, petitions the Legislature to adopt such legislation as will best effect this object.

It suggested that in order to protect the public health a law be enacted which shall embrace a number of provisions contained in the petition. Among these suggestions are: That if any person or persons shall sell or exchange, or offer for sale or exchange, or have in his, her, or their premises, with intent to sell or exchange, milk to which water, ice, coloring matter, or any other foreign substance shall have been added, or milk from which the cream, or any part thereof, shall have been removed, or milk taken from a cow fed upon distillery-waste or any other substance tending to make her milk unwholesome, or milk taken from a sick or diseased cow, or milk exposed to infection or unhealthy exhalations, or not of standard quality, shall be guilty of a misdemeanor, and upon conviction shall be sentenced to pay a fine not exceeding $100 or be imprisoned not over six months, or both or either, at the discretion of the Court.

Evaporated or condensed milk shall contain 25 per centum or more of fat, and milk containing 12 per centum of milk solids shall be deemed of standard quality, and all other milk shall be deemed not of standard quality. This does not apply to buttermilk.

In cities of the first class the Director of Public Safety is directed to appoint an Inspector of Milk, with assistants, clerks, analysts, and collectors of samples. The latter are directed to take a fair sample of any milk offered for sale, and for such purpose may enter all places where milk is stored or kept for sale, and have access to all wagons, carts, or other vehicles used for the conveyance of milk and open any vessel or package containing milk for sale or exchange. Whenever an Inspector or Collector takes a sample of milk he is required to divide it into two parts and put each into a separate can or vessel and seal (it) in the presence of the owner or owners or their agents or employes from whom the sample was obtained. One part shall be offered to the owner or owners, agents or employes, and the other shall be retained and analyzed or tested. Unless the provisions of this section are complied with the result of the test shall not be received in evidence in any prosecution brought under the Act. If any person or persons shall hinder, obstruct, or interfere with any Inspector, or Collector of samples in his collections, or if any person or persons use or have any imitation of the Collector's seal, they shall be guilty of a misdemeanor, the punishment, on conviction, being the same as referred to above.

It shall be unlawful in any city after an Inspector has been appointed for any person to sell or exchange milk without a license. All applications for a license are required to be made in writing to the Inspector of the Milk for the city for which the license shall be desired, which application shall contain the location of the place or places and the number of vehicles for which licenses are desired. It also provides that, unless City Councils make other provisions, the sum of $10 shall be tendered for each place, $5 for each vehicle, for which a license is desired. After application has been made, the Inspector shall issue a certificate to the applicant showing whether the license is for a place or vehicle. These licenses shall expire on the 1st of May of each year, and the Inspector is required to keep a record of all the licenses granted. Cities of the first class are empowered to substitute for the license charges named any sum deemed expedient. In cases of removal of location a fee of 25 cents is to be charged for changing the certificate and records.

Licenses may be transferred upon personal application to the Inspector and the payment of the fee of 25 cents for the changes made on the records. In all cases the certificates of licenses must be displayed conspicuously. If any person not licensed shall sell or exchange milk, or if any person make a false statement in application for a license or transfer, or if the certificate be not conspicuously displayed, or if milk be sold from a vehicle not properly marked, such person or persons so offending shall be guilty of a misdemeanor. It will be the duty of the Inspectors to cause the arrest of any person against whom they have sufficient evidence.

All moneys received from licenses, charges, and fees are to be paid into the City Treasury and shall constitute a separate fund to be appropriated by Councils.—*Telegraph*, Jan. 29, 1889.

New Method of Illuminating Internal Organs.

The Vienna correspondent of the *Lancet*, Jan. 5, 1888, says that the well-known experiment for showing total reflection of light in a jet of water or in a glass rod has been made use of in Vienna by Dr. Roth and Professor Reuss in devising a new method of illuminating from outside some cavities of the body, such as the larynx and nose. The instrument used for this purpose is a well-polished (not blackened) glass rod, to one end of which a small electric incandescent glow lamp, like those used for electric breast pins, is attached. The light of the lamp is reflected equally through the whole glass rod to its other end, which is placed on the skin of the throat in the case of a laryngoscopical examination being required; then the interior of the larynx becomes illuminated sufficjently for laryngoscopy. If this luminous glass rod is applied to the sclerotic, the interior of the eyeball can be examined in the same way as by using an ophthalmoscope, the structure of the posterior parts of the vitreous body being very well seen and studied. As the glass rod remains cold, it can be employed in operative surgery to light the natural and artificial cavities.

Evil Effects Following the Administration of Sulphonal.

Dr. Schotten, of Cassel, reports a case of this kind in the *Therapeutische Monatshefte*, Dec., 1888. A woman 45 years old, a hemiplegic since her twentieth year as the result of chronic myelitis, was a victim of wakefulness. Schotten gave the patient sulphonal, three days in succession, in doses of fifteen and 45 grains. Under its influence she was affected with extreme prostration, headache, anorexia, and a bitter taste in the mouth. Four days later her body was covered with an eruption resembling measles; at the same time the other symptoms attributed to the sulphonal disappeared. The eruption was accompanied with a sensation as of burning and of heat in the skin, and lasted fifteen days.

A sister of the patient had presented a similar eruption following the use of antipyrin.—*Gazette Médicale de Paris*, Dec. 29, 1888.

Therapeutics of Iodol.

Prof. Dante Cervesato, of Padua, has communicated to *Lo Sperimentale*, September, 1888, his experiences with the therapeutic use of iodol in internal diseases. It was first tried in scrofulosis, in all forms of which it acted well. It was most active in the torpid form, especially in torpid, swollen lymph glands which had not yet suppurated —and not only in the peripheral glands but also in the bronchial and mesenteric. It was less favorable in its action upon scrofulosis of the mucous membranes, especially of the nose and ear. It has very little influence upon scrofulous dermatoses. It was employed internally in doses of seven and a half, fifteen, and twenty-two and a half grains in older children, and the treatment could be kept up without harm for two or three months uninterruptedly. Iodoform ointment (one part to fifteen of vaseline) and insufflations of iodoform were useful adjuncts. The iodol was well borne; not only did no digestive disturbances occur, but the digestion even improved. In diseases of the respiratory organs iodol was given in doses of fifteen to forty-five grains a day, in addition to inhalations with the following solution: one part of iodol is dissolved in five parts of warm absolute alcohol; to the filtered solution ten parts of glycerine (at 60°—70°) are added. Before the solution cools, ten parts of water are added with constant stirring. The iodol remains proportionately suspended for a long time. Four drachms of the emulsion are used for each inhalation, which is given two or three times a day. He has observed marked improvement in primary tuberculosis of the larynx. In acute and chronic catarrhal laryngitis, and in different forms of bronchitis, the results were brilliant. In tertiary syphilis it was employed with very favorable results. Two patients with extensive ulcers on the palate and pharynx recovered after the internal and local use of iodol for two months. Internally iodol was given in doses of fifteen to forty-five grains; the following solution was used locally:

Iodol	gr. xv
Alcohol	ʒ iv
Glycerine	ʒ viii

M.

In a case of tertiary syphilis with lesions of the liver and of the larynx, the internal use of iodol achieved wonders. No iodisin nor any other disagreeable accompanying symptoms whatsoever occurred in any of the cases.—*Wiener med. Presse*, Dec. 2, 1888.

The Doctor as a Civilizer.

The large part played by medical travelers and missionaries in the most remote and uncivilized parts of the world in attracting the affection of savage populations, and leading them in the path of civilization, is not the least glorious page of medical history, and would afford material for an interesting research. Mr. George Curzon, in his account this month of a *Visit to Bokhara the Noble*, gives a highly interesting sketch of Dr. Heyfelder, who was chief of the medical staff in Skobeleff's Turcoman campaign. "It would be hard to exaggerate the part which his manners and generosity have played in the pacification of this whilom haunt of fanaticism. As early as six in the morning people crowd into the Embassy to see him. Very often so childish is their faith that they do not ask for a prescription, but simply implore his touch. . . . A fat old Bey, he told me, came to him one day and said: 'Can you make me better? I suffer from eating four dinners a day.' 'Certainly,' said the doctor, 'eat three.' Thereupon the old gentleman became very angry, and retorted, 'How can I eat less when I am called upon to entertain venerable foreigners?' I asked the doctor whether it was out of benevolence that he continued to reside in Bokhara. 'Yes,' he replied, 'and as a pioneer of civilization.'"—*British Med. Journal*, Jan. 12, 1889.

Statistics of Operations on the Gall Bladder.

Dr. A. Depage, in the course of a paper upon Surgical Intervention in Biliary Lithiasis (*Journ. de Méd. Brux.*, 1888, No. 24), says that up to the present there have been 78 cholecystotomies performed. Of these operations, 6 were done according to the method of Spencer Wells, 72 with suture of the gall bladder to the abdominal wall. Of the first-named series, 3 patients died from acute peritonitis, in 1 cured case there was recurrence, and 2 patients were completely cured. Of the second series there were 11 deaths, 5 from hemorrhage and collapse, 2 from biliary retention, 2 from effusion of bile into the peritoneum, and 2 from undetermined cause; there were also 4 deaths from secondary complications. Amongst the "cures" are 24 cases of biliary fistula, some permanent. The number of cholecystectomies has been 22, with 2 deaths from obstruction of the bile duct, and 1 after recovery from the operation from a cause independent of biliary lithiasis. Thus in cholecystotomy with suture of the gall bladder, and its return free into the abdominal cavity, a mortality of 50 per cent. resulted; in cholecystotomy with suture of the bladder to the parietes, 15.27 per cent.; and in cholecystectomy, 9.99 per cent.; and as the last-named figure comprises the two cases of permanent occlusion of the common bile duct, the result, if they be excluded, is to enhance greatly the position of cholecystectomy as an operation to be preferred to cholecystotomy.—*Lancet*, Jan. 12, 1889.

Frequency of Diseases of the Nose and Throat.

Dr. W. Franklin Chappell, Attending Physician to the Chest and Throat Department, Presbyterian Hospital, New York, has undertaken to ascertain the frequency of diseases of the throat and nose. In his paper, published in the *American Journal of Med. Sciences*, Feb., 1889, he gives some interesting details of his examination of the noses and throats of two thousand children. Nine hundred and fifty-five of these were from the New York Juvenile Asylum, six hundred and forty-five from the Grammar School No. 49, and two hundred from the Half Orphan Asylum in East 10th Street, and the remaining number from various sources.

In the entire number the following abnormal conditions were found: Adenoid growths, 60; enlarged tonsils, 270; deviated septa, 330; spurs on septa, 150; hypertrophy of inferior turbinated bodies, 260; hypertrophy of middle turbinated bodies, 161. This shows that 1231 were suffering from some anatomical abnormality, and usually with its accompanying symptoms of respiratory obstruction and catarrh.

After an analysis of these statistics, he expresses the opinion that enlarged tonsils and adenoid growths are the only anatomical abnormalities that can be classed as belonging to very early life. The other abnormal conditions are acquired usually after the age of six years, increasing rapidly with each succeeding year until puberty. All social classes are liable to them in about equal proportions, and at the same age. Males, he says, suffer more frequently than females, probably owing to greater exposure to the causes which produce catarrhal congestion and inflammation. In glandular organs it is but a step from congestion to hyperplasia, and an increased afflux of blood being once established, a slight irritation will serve to keep it up, and hypertrophy is the necessary result.

Hospitals for Contagious Diseases in Tennessee.

In his report to the State Board of Health of Tennessee, Jan. 8, 1889, the Secretary, Dr. J. B. Lindsley, spoke as follows:

"As to yellow fever we must not conceal the fact that the outlook is ominous. All sanitarians in the Southern States familiar with the past are very uneasy about the coming summer. There is but one way open to us, namely, to look the possibilities fairly in the face and be ready for any emergency.

"In this connection a local matter of great importance should not be overlooked. The four cities—Memphis, Nashville, Chattanooga, and Knoxville—each centres of great travel and traffic, visited by thousands annually, not only from Tennessee, but from States near and far, with large floating populations, should, without delay, provide suitable accommodations for the care and treatment of persons suffering from communicable diseases—ordinarily termed contagious or infectious. Such hospitals should be isolated, but not at too inconvenient a distance. They need not be large, but should be always equipped and ready for use, and competent physicians and nurses constantly retained for service. No one can tell when such hospitals will be wanted. These four cities are already noted and populous, rapidly growing also, and are without excuse for not making such provision for the stranger within their gates or their own people, many in number, who cannot be well cared for at home."—*Tennessee State Board of Health Bulletin*, Jan. 15, 1889.

What are we to Know?

Canon Isaac Taylor, in an address on "Literature and Culture," published in the *Church Worker*, has given some advice which, with some obvious modifications, doctors and medical students would do well to lay to heart. He said: "It is impossible for any one man to know everything—*omne scibile*. Two hundred years ago it was possible; but now the domain of knowledge has been so vastly extended that it is impossible. In these days, to be distinguished, a man must be a specialist—he must devote himself to some department of knowledge. It is impossible, for instance, that the same man can be at once a great historian and a great chemist. It was said of Whewell, that while science was his forte, omniscience was his foible. Because he knew so much, he thought he could know everything; and so, if you strive after universal knowledge, what you will attain will not be science, but sciolism. Strive after universal knowledge, and you will become a universal smatterer. On the other hand, the mere specialist tends to become a narrow pedant. How shall we avoid these opposite dangers—sciolism and pedantry? I think the best rule for a young man to set before him in his studies is, to resolve to know something of everything, and everything of something. To know everything of something is to choose some one branch of science for your specialty, and to learn everything that can be learned about it; this will give you accuracy and precision. To become 'an authority,' as it is called, on some one subject, however small—on butterflies, birds' eggs, or even on postage stamps—is better than nothing. Still better is it to take some department of history, or of geology, or of philology, and master it thoroughly. But this is not enough. You will thus learn to be accurate, exhaustive; but you will be narrow. You must not only know everything of something; but, to gain breadth of mind, you should also resolve to know something of everything. Strive to take a general interest in every department of human knowledge. Strive to know enough of every science to enable you to listen intelligently to any great specialist you may chance to meet, and to read with profit any great epoch-making book that may appear. Such knowledge cannot be deep; but such an imperfect knowledge adds immensely to the intellectual pleasures within your reach, and will constantly throw light on that one branch of knowledge which you have specially made your own."—*Bristol Medico-Chirurgical Journal*, Dec., 1888.

Naval Board of Medical Examiners.

The Board of medical officers is now convened at Philadelphia for the examination of applicants for appointment as assistant surgeons in the navy, and will remain until March 31; it has been ordered to meet at the Naval Hospital, Brooklyn, April 1, and to remain there until the following October. The change is made to enable students at the New York and Brooklyn hospitals to be examined by the Board without the expense of leaving their homes. There are fourteen vacancies in the grade of Assistant Surgeon. Further information may be obtained by addressing the President of the Examining Board.

NEWS.

—Small-pox of a malignant type is reported to be increasing in Nanticoke, Pa.

—Dr. Heinrich A. Pagenstecher, the eminent zoologist, has recently died at Hamburg.

—Dr. John A. Fisher died in New Orleans Jan. 15. He was a native of Lebanon, Pa.

—Dr. W. R. D. Blackwood was elected President of the Anti-Vivisection Society at its recent meeting Jan. 28, 1889.

—Dr. Charles Bliss died in New York City Jan. 23. He was graduated from the Berkshire Medical College in 1865.

—Prof. Ziegler of Tübingen has been invited to take to Professorship of Pathological Anatomy in the University of Freiburg.

—Dr. E. A. Neely, who has just withdrawn from the editorial staff of the *Memphis Medical Monthly*, was married at Memphis Jan. 23.

—Dr. John Underhill died in Cincinnati, Ohio, Jan. 28, from the effects of cocaine, to which he is said to have become habituated through experimentation.

—Typhoid fever is epidemic at Lake View, Cook county, Illinois. The *Journal of the Amer. Med. Association*, Feb. 2, says that there are now nearly fifty cases of the disease.

—The Eighth German Congress for Internal Medicine will be held in Wiesbaden from April 15 to April 18, 1889, under the presidency of Prof. von Liebermeister, of Tübingen.

—Dr. William A. Edwards has established a private Hospital at San Diego, Southern California. The nursing will be conducted by graduates of the Philadelphia Hospital Training School.

—A disease presenting some peculiar symptoms has made its appearance in Webster county, Kentucky. It seems to be traceable to impure water and poisoned atmosphere, and is said to be rapidly fatal.

—Another doctor has been beaten by White Caps who have committed some outrages at North Manchester, Indiana. Dr. W. H. Clair was recently assaulted on the principal street of the place and ordered to leave town. He was beaten over the head and shoulders with clubs, and then shot at, one of the bullets inflicting a painful wound.

HUMOR.

A FOND MOTHER of a smart boy was making a lot of nice preserves one day, and as she sealed them up she labelled them thus: "Gooseberry jam put up by Mrs. Mason." Johnnie soon discovered the shelf on which they were deposited, and fell to work. Having emptied one of the jars, he took his school pencil and wrote underneath the label: "Put down by Johnnie Mason."—*Am. Druggist.*

"MAY I LOOK through your waste-basket?" inquired a young man, entering timidly. "Certainly," said the editor. "What do you want to find?" "A little poem on 'Mortality' that I sent in yesterday." "My dear sir, that poem was accepted and will appear to-morrow. I will draw you a check for $25, and I assure you—" But he spoke to lifeless ears. The young man had fallen to the floor. The shock had killed him.

A DERMATOLOGIST, being seated by a lady unknown to him, at dinner, when conversation lagged, remarked interestedly, "Have you noticed the spots on that man's face across the table?" To which she indignantly replied, "Excuse me, sir; that is my husband!" The skin man, being a Briton, and so never to be crushed by circumstances, most enthusiastically said: "Ah! that *is* fortunate; then *you* can tell me whether he is spotted like that all over, *cawn't* you?"

OBITUARY.

MARTIN L. WEAVER, M.D.

Dr. Martin L. Weaver died at his residence in Germantown, Feb. 1. He was born in Germantown about eighty-four years ago. His grandfather, Martin Webber, came to America about 1714.

Dr. Weaver was graduated from the University of Pennsylvania in 1829, receiving his preliminary education at Princeton College. At one time he contemplated entering the ministry of the Presbyterian Church, and took a theological course at Carlisle. He never took a regular charge, but employed the greater portion of his time as co-executor of his father's estate.

Dr. Weaver came into prominence in the newspapers several years ago through the trouble between his daughter and his second wife. Efforts were made to have him adjudged insane and his marriage set aside, but the Courts decided in his favor.